Health Reimbursement Arrangement Plan Document

For New Jersey Schools Insurance Group
Health Reimbursement Arrangement
Effective September 1, 2007
Amended and Restated January 1, 2017

HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

The Plan Sponsor designated in the Employer's Adoption Agreement (hereinafter called "Company" or "Employer") hereby establishes a self-funded medical expense reimbursement arrangement, the "Plan", to be effective as of the Effective Date specified in Section 1.8, below.

This Plan has been established to reimburse the eligible Employees of the Employer for the reimbursement of allowable medical, dental and other similar expenses incurred by them, their Spouses and Dependents. It is intended that the Plan meet the requirements for qualification under Code Sec. 105, and that benefits paid Employees hereunder be excludible from their gross incomes by virtue of Sec. 105(b) and Sec. 106(a).

ARTICLE I
DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

1.1 "Adoption Agreement" means the separate agreement adopting the Employer's Plan.

1.2 "Affiliated Employer" refers to all employers that are connected to and/or associated with the hiring Employer that have adopted this Plan by signing the Employer's Adoption Agreement.

1.3 "Benefits" means the benefits provided for in the Employer's signed Adoption Agreement.

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

1.5 "Company" means the Employer, or any affiliate or successor thereof that adopts this Plan pursuant to the terms of the Employer's Adoption Agreement. Such term also includes any other organization that is a member of a controlled group of businesses within the meaning of Code

Sec. 414(b), (c) and (m) or any organization that is exempt from federal taxation under Code Sec. 501.

1.6 "Coverage Period" means the Plan Year, during which period the benefits provided by this Plan shall be available to a Participant hereunder.

1.7 "Dependent" means any individual who is a Qualifying Child or Qualifying Relative under Code Section 152 (as modified by Code Section 105(b)), as applicable. A Dependent also includes an adult child of a Participant who as of the end of the calendar year has not attained age 27. A child for purposes of this Section 1.7 means an individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed with the Participant for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law.

1.8 "Effective Date" means the Effective Date in the Employer's Adoption Agreement.

1.9 "Eligible Individual" means an Eligible Employee or Dependent who: (a) is covered under a qualifying High-Deductible Health Plan, in accordance with requirements set forth under Code Section 223(c)(2); (b) is not an individual that may be claimed as a Dependent by another person for tax purposes, under Code Section 151; (c) meets other applicable testing period requirements set forth under Code Section 223 generally; and (d) is not covered under any other health plan, with the exception of any policy or program that only provides coverage for the following:

(a) Accidents;

(b) Disability;

(c) Dental;

(d) Vision;

(e) Long-term care;

(f) Or other "permitted insurance" defined under Code Section 223(c)(3), as otherwise amended from time to time, including insurance for a specified disease or illness.

1.10 "Eligible Medical Expenses" means those expenses incurred by the Employee, or the Employee's Spouse or Dependents that are eligible for reimbursement, as determined by the Employer's Adoption Agreement and in accordance with Article IV, and are otherwise allowable as deductions under Code Secs. 105 and 213 (without regard to the limitations contained in Code Sec. 213(a)) and any accompanying regulations or other applicable Treasury guidance information. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense. However, the following shall not be considered as being eligible expenses:

(a) an illness or injury (or aggravation of an illness or injury) incurred by an Employee during a period of duty with the Uniformed Services.

(b) a medical expense incurred before the Plan is in existence.

(c) medical expenses incurred before the employee first becomes enrolled in the Plan.

(d) effective January 1, 2011, medical expenses related to any over-the-counter (OTC) medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

1.11 "Employee" means an individual described within the Employer's Adoption Agreement as being eligible to participate in this Plan. However, the term employee does not include a "self-employed individual", as defined in Code Sec. 401(c).

1.12 "Employer" means the Plan Sponsor and any Affiliated Employer which is listed on the Employer's Adoption Agreement; provided, however, that the Plan Sponsor retains authority as Plan Administrator for all purposes under the Plan and retains sole authority to amend or terminate the Plan in accordance with Article VIII, without the approval of any Affiliated Employer which has adopted the Plan.

1.13 "Entry Date" means the Effective Date provided for in the Plan Entry Date provision of the Employer's Adoption Agreement.

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

1.15 "FMLA" means the Family and Medical Leave Act of 1993 (29 USCS Section 2601 et seq.).

1.16 "FMLA Leave" means a leave of absence that the Company is required to extend to an Employee under the provisions of the FMLA.

1.17 "Health Savings Account" means an account established and maintained by the Plan in accordance with Code Section 223(d) to which part of any Eligible Employee's Flexible Benefits Plan Dollars may be allocated and from which all HSA Medical Expenses may be reimbursed or otherwise distributed as otherwise set forth herein.

1.18 "Highly Compensated Employee" means, for the purposes of determining discrimination, an Employee described in Code Section 105(h) and the Treasury regulations thereunder.

1.19 "Participant" means any Employee who has met the eligibility requirements set forth in Article III.

1.20 "Plan" means this instrument, including all amendments and attachments thereto.

1.21 “Plan Administrator” means the “plan sponsor” identified in the Employer’s Adoption Agreement, or any person or other third party appointed by the Company who has the authority and responsibility to manage and direct the operation and administration of the Plan.

1.22 “Plan Year” means the annual accounting period of the Plan as set out in the Employer’s

1.23 “Qualified HSA Distribution” means a direct distribution of an allowable amount from a Health Reimbursement Arrangement, as otherwise allowable based on the Employer's signed Adoption Agreement and as otherwise applicable under the Code, to an Eligible Individual's Health Savings Account.

1.24 “Retiree” means those terms as defined in the Employer’s Adoption Agreement.

1.25 “Spouse” means an individual who is legally married to a Participant, but shall not include an individual separated from the Participant under a legal separation decree.

1.26 “Uniformed Services” means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

All other defined terms in this Plan shall have the meanings specified in the various Articles of the Plan in which they appear.

ARTICLE II

ELIGIBILITY

2.1 General requirements

Any Employee of the Employer and its Affiliates who meets the eligibility requirements specified in the Employer’s Adoption Agreement shall be eligible to participate in the Plan on the Plan Entry Date specified in the Employer’s Adoption Agreement (or the Effective Date of the Plan, if later). An Employee may remain eligible to participate in the Plan under other coverage continuation circumstances stated within Article V below.

2.2 Reentry after Uniformed Service Duty

No reentry eligibility requirements will be imposed on any Employee who returns to active employment within 30 days of completing a period of absence from employment for duty in the Uniformed Services.

2.3. Termination of a Participant's Coverage

Except as provided in Article V, coverage of a Participant shall terminate automatically on the date

(a) the Participant terminates his employment;

(b) he is no longer in a class of Employees that is eligible for Plan coverage;

(c) of the Participant's death; or

(d) of termination of this Plan.

2.4. Termination of Coverage of an Eligible Dependent

Except as provided in Article V, an Eligible Dependent's coverage shall terminate—

(a) on the dates described in Section 2.3, as if the references to "Participant" were to "Eligible Dependent";

(b) for an Eligible Dependent other than the Spouse of a Participant, when an individual who had been an Eligible Dependent no longer qualifies as such.

2.5. Certificates of Coverage

The Plan normally will provide a Certificate of Coverage to any Participant or Dependent automatically after the individual loses coverage in the Plan. For the applicable timeframes when the Participant or Dependent has the right to elect Continuation Coverage, see Article VI. In addition, a Certificate will be provided upon request, if the request is made within 24 months after the individual loses coverage under the Plan. In that case, the Certificate will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish it. In either case, the Certificate will contain the following information:

(a) the date the Certificate was issued;

(b) the name of the group health plan that provided the coverage;

(c) the name of the Participant or Dependent to whom the certificate applies;

(d) the name, address, and telephone number of the Plan Administrator or issuer providing the certificate;

(e) a telephone number for further information (if different);

(f) either (i) a statement that the Participant or Dependent has at least 18 months (546 days) of Creditable Coverage, not counting days of coverage before a Significant

Break in Coverage (which means a period of 63 or more consecutive days during all of which an individual did not have any Creditable Coverage, exclusive of waiting periods and affiliation periods); or (ii) the date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and

(g) the date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate.

If the Plan is requested to provide a Certificate for a Dependent, the Plan will make reasonable efforts to obtain and provide that person's name. The Plan will not issue an automatic Certificate for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

For these purposes: (1) "Certificate of Coverage" means a written certification of the period of creditable coverage of the individual under the Plan and the coverage (if any) under COBRA continuation described in Article V, and the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under this Plan; and (2) "Creditable Coverage" means prior medical coverage that an individual had from any of the following sources: a group health plan (including this Plan), health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

Please note that effective for Plan Years beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar year Plans), Health Care Reform prohibits group health plans from imposing any pre-existing condition exclusions for individuals enrolled in the Plan who are under 19 years old; and effective for Plan Years beginning on or after January 1, 2014, there will be a complete prohibition against applying pre-existing conditions.

ARTICLE III

AMOUNT OF BENEFITS

3.1 Annual Benefits Provided by the Plan

Each Participant shall be entitled to reimbursement for his documented, Eligible Medical Expenses incurred during the Plan Year in an annual amount not to exceed the amount specified on the Employer's Adoption Agreement and in accordance with the payment ordering rules,

which determine whether benefits are paid under this Plan before or after some other plan or reimbursement arrangement.

Each Participant may also permanently opt out of and waive future reimbursements from the HRA at least annually, and upon termination of employment. However, upon opt out and waiver, any remaining amount in the HRA is forfeited.

If provided for under the Employer's Adoption Agreement, each Participant is entitled to carryover all or the allowable portion of any unused benefits to the subsequent plan year for use in that year, or any future periods in which the Participant remains eligible under the Plan.

3.2 Cost of Coverage

With the exception of coverage continuation situations under Article V below, the Employer shall bear the entire expense of providing the benefits set out in Section 3.1.

ARTICLE IV

PAYMENT OF BENEFITS

4.1 Eligibility for Benefits

Each Participant in the Plan shall be entitled to a benefit hereunder for all Eligible Medical Expenses incurred by the Participant on or after the effective date of his or her participation, (and after the effective date of the Plan) subject to the limitations contained in Article IV, below, regardless whether the mental or physical condition for which the Participant makes application for benefits under this Plan was detected, diagnosed, or treated before the Participant became covered by the Plan.

4.2 Claims for Benefits

No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits to the Plan Administrator on a form specified by the Plan Administrator, or pursuant to the procedures set out in Article VII, below. Upon receipt of a properly documented claim, the Plan Administrator shall pay the Participant the benefits provided under this Plan as soon as is administratively feasible. A Participant may submit a claim for reimbursement for an Eligible Medical or Dental Expense arising during the Plan Year at any time during the period that begins when the expense is incurred, and any unused Benefits may be carried forward for use in future years to the extent provided for within the Employer's Adoption Agreement.

The Participant may not submit a claim that is attributable to a deduction under Section 213 for any prior taxable year or any claim that was incurred before the individual became eligible for coverage under this Plan, or which has already been paid through any other

health insurance plan, Section 125 "cafeteria" plan, or other similar medical expense reimbursement arrangement.

The Participant may not submit a claim for individually-owned health insurance policy premiums.

4.3 Required Information

Each Participant's claim for benefits shall contain a written statement containing the following information:

(a) the person or persons on whose behalf Eligible Medical Expenses have been incurred;

(b) the nature of the expenses so incurred; and

(c) the amount of the requested reimbursement;

(d) a statement that such expenses have not otherwise been paid through insurance or reimbursed from any other source.

4.4 Repayment of Excess Reimbursements.

If a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses that have been properly substantiated during the Plan Year, or reimbursements have been made in error (for example, expenses were reimbursed for ineligible expenses or for an ineligible dependent), the Plan Administrator may recoup the excess reimbursements in one or more of the following ways: (i) the Plan Administrator will notify the Participant of the excess amount, and the Participant will be required to repay the Employer within sixty (60) days of receipt of notification; (ii) the Plan Administrator may offset the excess reimbursement against any other Eligible Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) the Plan Administrator may withhold the amount from the Participant's compensation to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursements, the Plan Administrator will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as any other bad business debt.

4.5 Reduction of Coverage to Prevent Discrimination.

If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any requirement imposed by the Code, the Plan Administrator shall take appropriate action(s), under rules uniformly applicable to similarly situated Participants, to assure compliance with the requirement or limitation. Action may include, without limitation, modifying or terminating Highly Compensated Employee's coverage under this Plan without the consent of the Employee.

4.6 Termination of Benefits

Unless coverage is continued in accordance with Article V, coverage under this Plan shall cease immediately upon any of the following events:

(a) a Participant is no longer employed by the Company;

(b) a Participant fails to return to active employment with the Company at the earlier of (i) the end of an FMLA Leave or (ii) the date the Participant who is on FMLA leave gives notice to the Company of an intent not to return to active employment; or

(c) the Participant fails to continue to fulfill the eligibility requirements as otherwise set forth herein.

Such Participant shall have the right to submit a claim for reimbursement, and receive benefits hereunder, for any Eligible Medical or Dental Expense arising during the Coverage Period at any time prior to the claims deadline described in Part A, General Information About Our Plan, in the Summary Plan Description.

4.7 Ordering Rules if a Health Reimbursement Plan is Offered in Conjunction with a Section 125 Flexible Spending Account

Unless the Employer's Adoption Agreement specifies that Eligible Medical Expenses under a Code Section 125 Flexible Spending Account must be reimbursed first before this Plan, if coverage for an Eligible Medical or Dental expense is provided under both a Code Section 125 Flexible Spending Account and the Plan, then the amounts available under the Plan must be exhausted before reimbursements can be made from the Flexible Spending Account. The Flexible Spending Account may then reimburse employees for those costs that are not covered by the Plan. The above notwithstanding, to the extent the Employer also sponsors a Section 223 Health Savings Account ("HSA") for the benefit of its Employees, Eligible Medical Expenses under this Plan shall only be paid in the manner specified under the Employer's Adoption Agreement or, alternatively if no elections have been made or an individual HSA exists, Eligible Medical Expenses shall only be paid after applicable HSA deductibles have been satisfied.

4.8 Family and Medical Leave Act of 1993

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's benefits under this Plan on the same terms and conditions as though he were still an active Employee, although the Employee may be responsible for the incremental cost of coverage continuation during such leave period (i.e., the Employee will remain eligible under the Plan to the extent the Employee opts to continue his coverage during the FMLA Leave period). If the Employee opts to continue his coverage, the Employee may pay his share of the applicable premium through whatever arrangements that are agreed upon between the Employee and Employer, as subsequently

administered by the Administrator (e.g., based on the Employer's direction, the Administrator may fund coverage during the leave and withhold "catch-up" amounts upon the Employee's return). Upon return from such leave, the Employee will be permitted to re-enter the Plan on the same basis the Employee was participating in the Plan prior to his leave, or as otherwise required by the FMLA.

Furthermore, if a Participant goes on a qualifying paid leave under the FMLA, to the extent required by the FMLA, the Employee will continue coverage while on FMLA by the method normally used during any paid leave.

ARTICLE V
CONTINUATION COVERAGE

5.1 Continuation Coverage after Termination of Normal Participation

During any Plan Year during which the Employer has more than twenty (20) employees (including persons who are considered to be "employees" within Code Sec. 401(c), directors, and independent contractors to the extent that any of the three categories is eligible to participate in this Plan), each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under this Plan upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage hereunder. Such extended coverage under the plan is known as "Continuation Coverage."

5.2 Who is a "Qualified Beneficiary"

A "Qualified Beneficiary" is any person who, as of the day before a Qualifying Event, (a) an Employee of the Employer (including persons who are considered to be "employees" within Code Sec. 401(c), directors and independent contractors) covered under the Plan as of such day (such persons are called "Covered Employees"), (b) the Spouse of the Covered Employee, or (c) a Dependent of the Covered Employee. (For these purposes, a Spouse or other Dependent is called a "Covered Dependent.") A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct), or reduction of hours of the Covered Employee's employment. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will be treated as a "Qualified Beneficiary".

5.3 Who is not a "Qualified Beneficiary"

A person is not a Qualified Beneficiary if, as of such day, either the individual is covered under the Plan by virtue of the election of continuation coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event, or is entitled to Medicare coverage under Title XVIII of the Social Security Act. Furthermore, an individual who fails to elect Continuation Coverage within the election period provided in Section 5.7, below, shall not be considered to be a Qualified Beneficiary.

5.4 What is a “Qualifying Event”

Any of the following is a “Qualifying Event”:

(a) Death of a Covered Employee.

(b) Termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of hours of employment below any minimum level of hours required for participation herein. In the case of a Covered Employee who:

  (i) does not return to covered employment at the end of an FMLA leave, the Qualifying Event of termination occurs on the *earlier* of the last day of the FMLA Leave or the date that the Employee notifies the Company of the intention not to return to active employment, or

  (ii) is absent more than 31 days due to a period of duty with the Uniformed Services, the Qualifying Event occurs on the first day of such absence.

(c) Divorce or legal separation of a Covered Employee from the Employee's Spouse.

(d) A Covered Employee's becoming entitled to receive Medicare benefits under title XVIII of the Social Security Act.

(e) A dependent child of a Covered Employee ceasing to be a Dependent.

(f) Retirement of the employee.

5.5 What Benefit Is Available under Continuation Coverage

Each person who is eligible to elect to continue coverage under Article V shall have the right to submit claims for eligible medical expenses equal to the unused reimbursement amount remaining at retirement or other termination of employment as well as reimbursement for any additional contributions made in accordance with the applicable COBRA election. If the employee elects COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) continuation coverage, then the Employer shall fund the account as provided in Section 5.12. Amounts paid will be reduced by any administrative costs for continuing such coverage.

5.6 Notice Requirements

(a) When an Employee becomes covered under this Plan, the Plan Administrator must inform the Participant (and spouse, if any) in writing of the rights to continued coverage, as described in Article V.

(b) The Employer shall give the Plan Administrator written notice of a Qualifying Event within thirty (30) days of the occurrence thereof.

(c) Within fourteen (14) days of receipt of the Employer's notice, the Plan Administrator shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the Plan, as well as a recital of the rights of any such Beneficiary to elect Continuation Coverage, as required by Code Sec. 4980B and ERISA Section 601, in accordance with the terms of this Plan.

(d) In the case of a Qualifying Event described in Section 5.4(c) or (e), a Covered Employee or a Qualified Beneficiary who is a Spouse or Dependent of such Employee must notify the Plan Administrator within sixty (60) days of the occurrence thereof. The Plan Administrator shall give written notification of Conversion Coverage rights to any other affected Qualified Beneficiary within fourteen (14) days of receipt of the notice described in this Section 5.6(d). Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

5.7 Election Period

Any Qualified Beneficiary entitled to Continuation Coverage shall have 60 days from the date of the notice required by Section 5.6, in the case of occurrence of a Qualifying Event, in which to return a signed election to the Plan Administrator indicating the choice to continue benefits under this Plan.

5.8 Duration of Continuation Coverage

(a) Continuation Coverage shall extend for a period of 18 months after the date that regular coverage ends due to the Employee's termination of employment or reduction of hours of employment to a level that disqualifies him or her from participation in the Plan, or for a period of 29 months if the Social Security Administration (SSA) determines within the 18-month period that any Qualified Beneficiary was disabled during the first 60 days of Continuation Coverage. However, if the Covered Employee was entitled to Medicare benefits at the time of the Qualifying Event of his or her termination of employment or reduction of hours, each Covered Dependent shall be eligible to continue coverage for up to 36 months from the date the Covered Employee first became so entitled. For purposes of determining continuation coverage rights “entitlement” means actual enrollment for Medicare benefits.

(b) In order to secure the extended coverage after a determination of disability, the disabled Qualified Beneficiary must notify the Plan Administrator of SSA's finding within 60 days of its issue. If, during the 18-month period, a subsequent Qualifying Event occurs, the Covered Employee and each other Qualified Beneficiary having Continuation Coverage shall be entitled to elect to continue coverage under the Plan for up to 36 months following the date coverage was originally lost due to termination of employment or reduction of hours.

(c) In addition, 36 months of Continuation Coverage shall be available to: (i) the Employee's spouse who loses coverage under this plan by ceasing to be a "Dependent" (as defined in Section 1.7) by virtue of a divorce or legal separation; (ii) a dependent child of the Employee who loses coverage by ceasing to be a dependent as defined by Code Sec. 152; (iii) any Covered Dependent who loses coverage where the Qualifying Event is the Employee's death; (iv) any Covered Dependent, where the Employee's entitlement to Medicare benefits results in loss of coverage under this Plan; or (v) any of the Employee's Covered Dependents if the Qualifying Event is the Employer's entering bankruptcy proceedings (or 36 months from the Employee's death, if later). In no event, however, shall Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

5.9 Automatic Termination of Continuation Coverage

Continuation Coverage shall automatically cease if (a) the Employer no longer offers the Plan coverage to any of its employees, (b) the required premium for continuation coverage is not paid within 30 days of the date due, (c) an electing Beneficiary becomes covered under another group health plan, or (d) an electing Beneficiary becomes entitled to receive benefits under Medicare.

Upon the termination of the Continuation Coverage, the Plan will only reimburse the former employee for medical care expenses only up to an amount equal to the unused reimbursement expenses that were incurred prior to the end of the period in which eligibility for coverage continued. Claims for any benefits must also be made in accordance with Section 4.2.

5.10 Continuation Coverage for Employees in the Uniformed Services

For purposes of this Article V, an Employee is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services has a Qualifying Event as of the first day of the Employee's absence for such duty. Such an individual shall be treated as any other Qualified Beneficiary for all purposes of COBRA under this Article V. The Plan Administrator shall furnish the Employee a notice of the right to elect COBRA continuation coverage (as provided in Section 5.6) and shall afford the Employee the opportunity to elect such coverage (in accordance with Section 5.7), except the maximum period of coverage available to the Covered Employee and the Employee's Covered Dependents is the lesser of (a) 18 months beginning on

the date of the employee's absence or (b) the day after the date on which the employee fails to apply for or return to active employment with the Employer.

5.11 Premium requirements

(a) A Qualified Beneficiary who has elected Continuation Coverage under this Article V must pay a premium of 102% of the applicable premium for the period of coverage. In the case of an individual who is determined to have been disabled (as described in Section 5.8(b)), the premium for Continuation Coverage is 150% of the applicable premium for any month after the eighteenth (18th) month of Continuation Coverage, as described in Section 5.8.

(b) The required premium for Continuation Coverage may, at the Qualified Beneficiary's election, be paid in monthly installments.

(c) Premiums for Continuation Coverage become payable 45 days after the day on which the Qualified Beneficiary makes the initial election for Continuation Coverage.

(d) “Applicable premium” means the incremented cost of providing the coverage under the Plan, up to the maximum reimbursement amount, as is provided to other similarly-situated non-COBRA beneficiaries.

5.12 COBRA continuation coverage requirements

If an employee elects COBRA continuation coverage, then the Employer fulfills the COBRA requirement as provided in Section 4980B by increasing the amount available to the Employee under the Plan by the same increment as similarly situated non-COBRA beneficiaries.

ARTICLE VI

PLAN ADMINISTRATION

6. 1 Allocation of Authority

Except as to those functions reserved within the Plan to the Employer or the Employer's board of directors (the “Board”), the Plan Administrator shall control and manage the operation and Administration of the Plan. The Plan Administrator shall have the exclusive right (except as to matters reserved to the Board by the Plan or which the Board may reserve to itself) to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator or the Board with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as it may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as shall be deemed necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan;

(d) To determine the amount of benefits that shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer, as appropriate, of the amount of such Benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part; and

(e) To designate other persons to carry out any duty or power which would otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan.

6.2 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Board, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. The Plan Administrator, the Employer (and any person to whom it may delegate any duty or power in connection with the administration of the Plan), and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant, (including Employees who are actuaries or accountants), consultant, third party administration service provider, legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive and binding as to all persons.

6.3 Fiduciary Liability

To the extent permitted by law, neither the Plan Administrator nor any other person shall incur any liability for any acts or for failure to act except for his own willful misconduct or willful breach of this Plan.

6.4 Compensation of Plan Administrator

Unless otherwise agreed to by the Board, the Plan Administrator shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of his duties shall be paid by the Employer.

6.5 Bonding

Unless otherwise determined by the Board, or unless required by any Federal or State law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

6.6 Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third party administrative service provider, actuary, consultant, accountant, attorney, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, shall be paid by the Employer, provided, however that each Participant shall bear the monthly cost (if any) charged by a third party administrator for maintenance of his Benefit Account unless otherwise paid by the Employer.

6.7 Funding Policy

The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and shall be retained by, the Employer.

6.8 Source of Payments

The Employer shall cause the trustee to pay any non-insurance benefits to which a Participant is entitled under this Plan from the trust created herein.

6.9 Disbursement Reports

The Plan Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's general assets pursuant to the provisions of the Plan.

6.10 Timeliness of Payments

Payments shall be made as soon as administratively feasible after the required forms and documentation have been received by the Plan Administrator.

6.11 Requirement that Participants Substantiate Reimbursable Expenses

Each Participant must submit a written claim voucher to the Plan Administrator to receive reimbursements from the Plan on a form provided by the Plan Administrator, along with such evidence as the Plan Administrator reasonably may deem necessary to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed. Year-end expense

reimbursement claims must be submitted to the Plan Administrator within the run-out period described in Part A, General Information About Our Plan, in the Summary Plan Description.

6.12 Periodic Account Statements

The Plan Administrator shall, on a periodic basis, provide each Participant with a statement of his medical and dental expense reimbursement account balance, as well as provide a copy of such information to any Participant who makes a specific written request.

ARTICLE VII

CLAIMS PROCEDURE

7.1 Method of Benefit Payment

(a) The Administrator shall make any and all payments or other reimbursements of Eligible Medical Expenses in the manner specified under Section 4.2, unless otherwise specified herein or as otherwise elected by the Employer (e.g., direct reimbursement by check, automatic deposit via automated clearing house (ACH), etc.).

(b) As an alternative to the method of Benefit payment referenced in Section 4.2 above, if an Eligible Employee agrees to the terms and conditions of any applicable cardholder agreement that provides for the payment of Eligible Medical Expenses through use of a debit or credit card, stored value card or other similar electronic media (hereinafter the "Debit Card"), payments under this Plan shall be made directly to the service provider, authorized merchant or other independent third party that provides products or services that are eligible for payment of Eligible Medical Expenses as otherwise set forth herein.

> (i) Within the cardholder agreement, the Eligible Employee agrees that payment for Eligible Medical Expenses can only be made on behalf of the Employee, the Employee's spouse or other qualifying dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth in the Employer's signed Adoption Agreement or as otherwise specified by the Employee's signed Election. The Employee also certifies that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. The Employee-cardholder also understands that the certification, which shall be printed on the back of the Debit Card, is reaffirmed each time the card is used. The Employee-cardholder also agrees to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate or as required by law. The Employee-cardholder also understands that the Debit Card is automatically cancelled when the Employee ceases to participate in the Plan, or under such other situations that are otherwise set forth within the cardholder agreement itself.

(ii) Unless other more stringent procedures or requirements are implemented and communicated to the Employer and its Employees, the Administrator agrees that it shall adhere to the terms and conditions of any separate Employer cardholder servicing agreement, including but not limited to a requirement to maintain the program in compliance with applicable standards under the Internal Revenue Code and any mandates that payments for Eligible Medical Expenses only be made to authorized merchants and service providers. The Administrator also agrees that it shall establish and maintain procedures for substantiation of any payments after the card has been used, for Eligible Medical Expense payments that are in accordance with applicable provisions of the Code, any underlying Regulations and other applicable guidance thereunder.

(iii) If any claim reimbursement request is being submitted in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator may make a conditional payment of an allowable Eligible Medical Expense reimbursement item to the authorized service provider, merchant, or approved independent third party, but shall also require the Participant-cardholder to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which shall be subject to further review and substantiation.

(iv) If any conditional payment has been made but is subsequently not deemed to be an Eligible Medical Expenses reimbursement, the Administrator shall ensure that proper correction procedures are maintained with respect to the improper payment(s):

(A) Upon identification of any improper payment, the Administrator shall require the Employee to pay back to the Plan an amount equal to the improper payment;

(B) If the Employee does not immediately repay the Plan, the Administrator shall ensure that the proper amount is withheld from the Employee's wages or other compensation (with such amounts then being immediately remitted to the Plan by the Employer) to the extent consistent with applicable law;

(C) To the extent that neither (A) nor (B) above are allowable or effective, the Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to the Employee-cardholder as part of his Employee cardholder agreement.

(D) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the Debit Card until the indebtedness is repaid by the Employee. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or Employee cardholder agreement.

(v) If a Participant attempts to utilize the Debit Card for any improper or non-allowable purpose, the Participant shall be responsible for any and all fees or other

expenses, including restitution or other similar penalty amounts, charged inappropriately by the Participant.

7.2 Procedure if Benefits are Denied under the Plan

Any claim for Benefits shall be made to the Administrator. If the Administrator denies a claim or rescinds Benefits under the Plan, the Administrator may provide notice to the Participant or beneficiary, in writing, within 30 days after the claim is filed unless special circumstances require an additional 15 days to review the claim. The Participant will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that the Participant needs to provide additional information, the Participant will have 45 days from the notice of the extension to obtain that information. The time period during which the Administrator must make a decision will be suspended until the earlier of the date that the Participant provides the information or the end of the 45-day period. If the Administrator does not notify the Participant of the denial of the claim within the 30-day period specified above, then the claim shall be deemed denied. The notice of a denial of a claim shall be written in a culturally and linguistically appropriate manner calculated to be understood by the claimant and shall set forth:

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

(b) The reason(s) for the denial;

(c) Specific reference to the provisions of the Plan on which the denial was based;

(d) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;

(e) A description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the Participant's right to bring a civil action under Section 502 of ERISA following a final appeal;

(f) A statement of a Participant's right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;

(g) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon written request;

(h) The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

7.3 Right to Request Hearing on Benefit Denial

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

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

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

(a) was relied upon in making the claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

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

The Plan Administrator will provide a claimant with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

7.4 Disposition of Disputed Claims

Upon its receipt of notice of a request for review, the Plan Administrator shall make a prompt decision on the review. The decision on review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based. The decision on

review shall be made not later than sixty (60) days after the Plan Administrator's receipt of a request for a review. If notice of the decision on the review is not furnished in accordance with this Section, the claim shall be deemed denied and the claimant shall be permitted to exercise his right to legal remedy pursuant to Section 7.4.

7.5 External Claims Review

After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the Plan a request for an external review, but only if the request for a review involves a claim denied either for medical judgment (for example, medical necessity), or a rescission of coverage. Medical judgment is determined by the external reviewer, who makes the ultimate determination as to whether a claim is eligible for external review. A claimant may request from the Plan Administrator additional information describing the Plan's external review procedure.

7.6 Preservation of Other Remedies

After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article VII, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law.

ARTICLE VIII

AMENDMENT OR TERMINATION OF PLAN

8.1 Permanency

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 8.2 and 8.3, below.

8.2 Employer's Right to Amend

The Employer reserves the right to amend the Plan at any time and from time-to-time, and retroactively if deemed necessary or appropriate to meet the requirements of Code Sec. 105, or any similar provisions of subsequent revenue or other laws, or the rules and regulations in effect under any of such laws or to conform with governmental regulations or other policies, to modify or amend in whole or in part any or all of the provisions of the Plan. Any amendment shall be effected by a written resolution adopted by a majority of the Board.

8.3 Employer's Right to Terminate

The Employer reserves the right to discontinue or terminate the Plan at any time without prejudice, provided that plan termination must be effected by a written resolution adopted by a majority of the Board. This Plan also shall terminate automatically if the Company (1) is legally dissolved, (2) makes a general assignment for the benefit of its creditors, (3) files for liquidation under the Bankruptcy Code, (4) merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Company's successor in interest agrees to assume the liabilities under this Plan as to the Participants and Eligible Dependents.

ARTICLE IX

GENERAL PROVISIONS

9.1 Relationship to a Cafeteria Plan

If an employer offers health care benefits under a cafeteria plan as provided under Section 125 of the Code, then an employee may also participate in this Plan as well. However, for purposes of funding the Plan, as provided in Section 3.2, the Employer shall bear the entire cost associated with the funding of the Plan. An arrangement which permits an employee to salary reduce to indirectly fund the Plan will disqualify such Plan and the arrangement will be subject to the provisions of Section 125.

9.2 Non-Discrimination Requirements

To the extent that the Plan is treated as a self-insured medical expense plan under Reg. Section 1.105-11, it must comply with the non-discrimination requirements as set forth under Section 105(h).

9.3 No Employment Rights Conferred

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

9.4 Payments to Beneficiary

Any benefits otherwise payable to a Participant following the date of death of such Participant shall be paid to his spouse, or, if there is no surviving spouse, to his estate, but only to the extent such benefits are related to Eligible Medical Expenses incurred by the Participant or his eligible dependents prior to his date of death.

9.5 Non-alienation of Benefits

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person. If any person entitled to benefits under the Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge any benefit under the Plan, or if any attempt is made to subject any such benefit to the debts, contracts, liabilities, engagements or torts of the person entitled to any such benefit, except as specifically provided in the Plan, then such benefit shall cease and terminate in the discretion of the Plan Administrator, and he may hold or apply the same or any part thereof to the benefit of any dependent or beneficiary of such person, in such manner and proportion as he may deem proper.

9.6 Mental or Physical Incompetency

If the Plan Administrator determines that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, he may cause all payments thereafter becoming due to such person to be made to any other person for his benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Plan Administrator and the Employer.

9.7 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because he cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identity or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due shall be forfeited and returned to the Employer.

9.8 Requirement of Proper Forms

All communications in connection with the Plan made by a Participant shall become effective only when duly executed on forms provided by and filed with the Plan Administrator.

9.9 Source of Payments

The Employer shall be the sole source of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

9.10 Tax Effects

Neither the Company nor the Plan Administrator makes any warranty or other representation as to whether any payments received by a Participant hereunder will be treated as includible in gross income for federal or state income tax purposes.

9.11 Multiple Functions

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

9.12 Gender and Number

Masculine pronouns include the feminine as well as the gender neutral, and the singular shall include the plural, unless indicated otherwise by the context.

9.13 Headings

The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

9.14 Applicable Laws

The provisions of the Plan shall be construed, administered and enforced according to applicable Federal law and the laws of the State as stated in the Employer Adoption Agreement.

9.15 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

ARTICLE X
HIPAA PRIVACY

10.1 Definitions

In addition to the specific definitions set forth below, all other capitalized terms used that are not otherwise defined herein have the meanings ascribed in HIPAA:

(a) "Designated Record Set" has the meaning in 45 CFR Section 164.501.

(b) "Electronic Media" has the meaning in 45 CFR Section 160.103, which is:

1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/ transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

(c) "Electronic Protected Health Care Information" (also known as "ePHI") has the meaning in 45 CFR Section 160.103, and is limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of the Plan.

(d) "Plan Administration Functions" is defined as activities that would meet the definition of Payment or Health Care Operations by HIPAA as set forth in 45 C.F.R. Section 164.501, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administration includes quality assurance, claims processing, auditing, monitoring, and management of carve-out Plan (i.e., vision and dental). Plan administration does not include any employment-related functions or functions in connection with any other benefits or benefit Plan, and the Plan(s) may not disclose information for such purposes absent an authorization from an individual for whom the information pertains. In addition, enrollment functions performed by Company are not considered as Plan Administration Functions.

(e) "PHI" is defined as Protected Health Information, as set forth in 45 C.F.R. Section 164.501. It is information that is created or received by a health plan, employer, health care provider, or health care clearing house and includes information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. In addition, the information either identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. This information may be maintained or transmitted either electronically or in any other form or medium.

f) "Secretary" means the Secretary of the Department of Health and Human Services or designee.

g) "Security Incident" has the meaning in 45 CFR Section 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(h) "Summary Health Information" is defined by HIPAA as set forth in 45 C.F.R. Section 164.504 as information that may be PHI, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom

Company has provided health benefits under the Plan; and from which the following information has been deleted, except that the geographic information described in (2) below need only be aggregated to the level of a five digit zip code.

(1) Names;

(2) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(A) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(B) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(3) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(4) Telephone numbers;

(5) Fax numbers;

(6) Electronic mail addresses;

(7) Social security numbers;

(8) Medical record numbers;

(9) Health plan beneficiary numbers;

(10) Account numbers;

(11) Certificate/license numbers;

(12) Vehicle identifiers and serial numbers, including license plate numbers;

(13) Device identifiers and serial numbers;

(14) Web Universal Resource Locators (URLs);

(15) Biometric identifiers, including finger and voice prints;

(16) Full face photographic images and any comparable images; and

(17) Any other unique identifying number, characteristic, or code.

10.2 Disclosure of Summary Health Information

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to Company, if Company requests the Summary Health Information for the purpose of:

(a) Obtaining premium bids from health Plan for providing health insurance coverage under the Plan; or

(b) Modifying, amending, or terminating the Plan.

10.3 Disclosure of PHI

The Plan may release PHI to the Company, so long as the Company agrees to do the following:

(a) Company shall not use or further disclose the PHI other than as permitted or required by the Plan's documents or as required by law;

(b) Company shall ensure that any agents, including a subcontractor, to whom it provides PHI shall agree to the same restrictions and conditions that apply to Company with respect to such PHI;

(c) Company shall not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Company;

(d) Company agrees to report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures providing herein, if and when Company becomes aware of such inconsistent use or disclosure;

(e) Company, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with Company Privacy Policy, has authorized the Plan to make PHI available to individuals;

(f) Company, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.524 and consistent with Company Privacy Policy, has authorized the Plan to make PHI available to individuals for amendment and to incorporate such amendments of PHI;

(g) Company, in accordance with HIPAA as set forth in 45 C.F.R. Section 164.528 and consistent with Company Privacy Policy, has authorized the Plan to make available the information required to provide an accounting of disclosures;

(h) Company, agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for purposes of determining the Plan's compliance with HIPAA; and

(i) If feasible, Company shall return or destroy all PHI that Company received from the Plan and which Company no longer needs for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, Company shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

j) Company agrees to use appropriate safeguards to prevent unauthorized use or disclosure of PHI, and have reasonable and appropriate safeguards in place to protect the confidentiality, integrity and availability of ePHI;

k) Company agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement;

l) Company agrees to report to the Plan, any use or disclosure of PHI of which it becomes aware that is not permitted or required by HIPAA; and

m) Company agrees to report to the Plan any Security Incident of ePHI of which it becomes aware.

10.4 Adequate Separations

The Company shall ensure that the following adequate separations are established:

(a) Company shall designate specific people who shall use and disclose PHI on behalf of the Plan for purposes of Plan Administration Functions. The Plan shall use and/or disclose (as proscribed in Section 10.5) PHI to the following people:

(i) Plan Administrator
(ii) HIPAA Privacy Official
(iii) Other Personnel, specifically designated by the Plan's Privacy Official

(b) Access and use of PHI by the Group shall be limited to Plan Administration Functions that Company performs on behalf of the Plan;

(c) Any issues of non-compliance by the Group shall result in disciplinary measures specified in Company Privacy Policy.

10.5 Uses and Disclosures.

The Plan may:

(a) Disclose PHI to Company in order for Company to carry out Plan Administration Functions consistent with the provisions of Subsections (a) through (m) of Section 10.4 above;

(b) Permit an insurance plan, insurance service, insurance organization, or HMO to disclose PHI to Company, so long as the disclosure is made to a person listed in the Group, and the disclosure is only for the purpose described in this Section 10.5;

(c) Not disclose or permit an insurance, insurance service, insurance organization, or HMO to disclose PHI to Company unless Company's privacy notice contains a provision which permits such disclosure; and

(d) Not disclose PHI to Company for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Company.

Summary Plan Description

For New Jersey Schools Insurance Group Health Reimbursement Arrangement Effective September 1, 2007 Amended and Restated January 1, 2017

HEALTH REIMBURSEMENT ARRANGEMENT

Summary Plan Description

INTRODUCTION

We are pleased to announce that we have established a medical expense reimbursement program for you and other eligible employees. Under this program, you will be able to receive reimbursement for the cost of eligible medical, dental or other similar expenses without taxation to you individually. The purpose of this Summary Plan Description is to briefly describe the expenses that qualify for reimbursement, as well as provide an outline of other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

However, one of the most important features of our Plan is that the cost of all benefits being offered to you within this Plan are entirely paid for by us, the Employer, at no additional cost to you or your family.

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a participant. You should direct any questions you have to the Administrator. There is a Plan document on file, which you may review if you desire. In the event there is a conflict between this Summary Plan Description and the Plan document, the Plan document will control. Also, to the extent there are any type of insurance contracts that exist to provide any portion of benefits under this Plan, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract would control.

PART A
GENERAL INFORMATION ABOUT OUR PLAN/ADOPTION AGREEMENT

This Section contains certain general information, which you may need to know about the Plan.

1. **General Plan Information**
New Jersey Schools Insurance Group Health Reimbursement Arrangement is the name of the Plan.

2 (a). **Plan Effective Date**
The provisions of your Plan became effective on September 1, 2007, which is called the Effective Date of the Plan.

2 (b). **Amended and Restated Date**
The provisions of the amended Plan became effective on January 1, 2017.

2 (c). **Original Plan Effective Date**
If amended and restated the Plan was originally effective on September 1, 2007.

3 (a). **Plan Year**

☒ Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The initial Plan begins on September 1, 2007, and ends on December 31, 2007. Future Plan years will be based on a full twelve-month period beginning on each January 1 and ending each December 31.

☐ Your Plan is a Perpetual HRA with a plan start date that begins _______.

3 (b). **Short Plan Year**

If your plan is not perpetual, the records are maintained on a twelve-month period of time. This is known as the Plan Year. The initial Plan Year is a short Plan Year that begins on September 1, 2007, and ends on December 31, 2007.

4. **Plan Number**

Your Employer has assigned Plan Number 535 to your Plan.

5. **Employer Information**

Your Employer's name, address and identification number are:

New Jersey Schools Insurance Group
6000 Midlantic Drive, Suite 300
Mount Laurel, NJ 08054
Federal Tax Id: 22-2887094

6. **Governing Body**

The Plan shall be governed under the laws of the State of New Jersey or the Commonwealth of _______.

7. **Plan Administrator Information**

The name, address and business telephone number of your Plan's Administrator (also referred to as the "Administrator") is:

New Jersey Schools Insurance Group
6000 Midlantic Drive, Suite 300
Mount Laurel, NJ 08054
609.386.6060

The Administrator keeps the records for the Plan and is responsible for the Plan. The administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

8. **Service of Legal Process**

The Administrator is the Plan's agent for service of legal process.

9. **Type of Administration**

The type of Administration is Employer Administration.

10. **Eligibility Requirements**

Retirees:

For purposes of determining continued eligibility under the Plan, Retirees shall be eligible to continue participation in the Plan.

"Retirees" shall only be considered as those employees who have satisfied the Employer's terms and conditions for retirement. For our Plan, "Retirement" shall be considered as being only those employees who have at least 25 years of service and have reached the minimum age of 60.

Plan entry is optional for a former employer who retires after 25 years of service with the company and is at least 60 years of age

Terminated employees shall:
☒ Cease to be a participant in accordance with Section 4.4 of the Plan. They shall have 30 days from their termination date to submit expenses for reimbursement for expenses incurred up to their termination date.

☐ Continue to be a participant for ___months/years or for as long as funds remain in his/her account. The funds available for reimbursement will be the amount in the HRA account on their termination date.

11. **Plan Entry Date**

The Entry Date for eligible Employees shall be: 25 days after date of hire

12. **Benefits**

The Plan shall reimburse Eligible Employees for the cost of Eligible Medical Expenses (as defined under Internal Revenue Code Sections 105 and 213 (without regard to the limitations contained in Code Sec. 213(a)),and any accompanying regulations or other applicable Treasury guidance information and as further described below), subject to the Annual Limit. None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred.

Types of Eligible Medical Expenses: The following types of Medical Expenses qualify for reimbursement under the Plan:

☒ All IRS Eligible Expenses

-OR-

☐ Medical Coinsurance
☐ Medical Copay
☐ Medical Deductible
☐ Prescription Drugs
☐ Dental Expenses
☐ Vision Expenses

☐ Premium Only - Only the employee's applicable premium of the following employer-provided insurance coverages:

☐ Health Insurance Premiums
☐ Dental Insurance Premiums
☐ Disability Insurance Premiums
☐ Long-term Care Insurance Premiums

If a deductible applies, benefits under this Plan shall be paid:

☐ BEFORE the employee is responsible for his portion of the deductible limit
☒ AFTER the employee's portion of the deductible limit is paid

Note: If the Employer also sponsors a Section 223, Health Savings Account, qualifying Medical Expenses shall be limited in accordance with the Benefit ordering rules discussed below.

13. **Annual Limit**

Health Reimbursement Arrangement is subject to an annual limit of “$ 6,000.00”.

This Plan ☐ is ☒ is not interest-bearing.

Newly-eligible participants may have access to a pro-rated amount based on months remaining in Plan Year at the time of plan entry.

The account will be funded at an amount of $500 on the first of each month of the plan with a maximum total of $6,000 for each plan year.

14. **Access to Benefits**

Other than for Retiree/COBRA continuants, the employer shall make all contributions for this Plan. The employer shall make access to benefits under the plan on a monthly basis at the beginning of each month within the Plan Year.

15. **Order of Benefit Payments**

If the Employer sponsors a Section 125 Flexible Spending Arrangement, in addition to this Plan:
☒ Eligible Medical Expenses must be paid under the Section 125 Plan before this Plan
☐ Eligible Medical Expenses must be paid under the Section 125 Plan after this Plan
☐ Applicable Health Insurance premiums are paid under this Plan before being paid under the Section 125 Plan

If the Employer also sponsors a Section 223, Health Savings Account (“HSA”) program for eligible employees, this Plan shall ☐ suspend payment of all Eligible Medical Expenses until all HSA deductible limits have been satisfied; ☐ only pay Limited benefits (including Dental and Vision expenses, but not Medical expenses) prior to or commensurate with the satisfaction of deductibles (and subject to the ordering rules with the applicable Section 125 Flexible Spending Arrangement as set forth above).

16. Carry over amounts

☐ $___ OR ☐ ___% of the ☐ Annual Limit ☐ Account Balance can be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution by the employer. Account Balance is not to exceed $_____. None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred.

17. Claims Deadline

<u>Mid-Year Claims Deadline Run-Out Period (Applies to Mid-Year Term or Cancel):</u>

30 Days after Coverage End Date

<u>End-of-Plan Claims Deadline (Run-Out Period):</u>

1 Months after Plan End Date

18. Claims

Outstanding claims ☐ may ☒ may not be considered for the next plan year.

19. COBRA Continuation

Qualified employees ☒ must ☐ may not be required to elect COBRA continuation for Employer sponsored medical insurance before being eligible to elect COBRA continuation for the Heath Reimbursement Arrangement, to the extent the Employer is subject to COBRA as set forth in the relevant Code, Employees Retirement Income Security Act of 1974 ("ERISA"), and/or Public Health Safety Act ("PHSA") statutory provisions and the applicable regulations promulgated thereunder..

20. Name and Address of Plan Continuation Coverage Administrator

New Jersey Schools Insurance Group
6000 Midlantic Drive, Suite 300
Mount Laurel, NJ 08054

21. Rights Upon Termination

If terminated Employees waive Continuation Coverage rights, the Spend-Down Option ☐ is ☒ is not offered.

22. Affiliated Employers participating in the Plan

23. HRA Funding

The HRA is funded with: ☒ General Assets; or ☐ A Trust.

Authorized Signatures:

Date ____________________________ Employer	By ____ Authorized Signature
Date___________________________ Employer	By ____ Authorized Signature
Date__________________________ Employer	By____ Authorized Signature
Date__________________________ Employer	By____ Authorized Signature
Date__________________________ Employer	By____ Authorized Signature

Corporate Resolution

For New Jersey Schools Insurance Group
Health Reimbursement Arrangement
Effective September 1, 2007

Certificate of Corporate Resolution

The undersigned Secretary or Principal of New Jersey Schools Insurance Group (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer on ______________________ and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of Health Reimbursement Arrangement effective September 1, 2007, presented to this meeting is hereby approved and adopted and that the duly authorized agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

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

RESOLVED, that the duly authorized agents of the Employer shall act as soon as possible to notify the Employees of the Employer of the adoption of the Health Reimbursement Arrangement by delivering to each Employee a copy of the summary description of the Plan in the form of the Summary Plan Description presented to this meeting, which form is hereby approved.

The undersigned further certifies that attached hereto as Exhibits A and B, respectively, are true copies of the Health Reimbursement Arrangement and Summary Plan Description approved and adopted in the foregoing resolutions.

____
Secretary/Principal

____
Date

PART B
QUESTIONS & ANSWERS

I-1. What is the purpose of the Plan?

The purpose of the Plan is to provide a source of funds to reimburse you or your dependents that are covered under the Plan for some or all of the uninsured medical expenses you incur in the course of each year while you are employed with the Company and the Plan remains in effect.

I-2. When did the Plan take effect?

Please refer to Part A, "General Information About Our Plan," subsection (2), of this document for a description of the "effective date" for our Plan.

I-3. Who can participate in the Plan?

You will be eligible to join the Plan once you have satisfied the conditions for eligibility. If you are not eligible to participate in this Plan on the Effective Date of the Plan, you will be eligible to join the Plan once you have satisfied the Eligibility Requirements under this Plan. Please refer to Part A, "General Information About Our Plan," subsection (10), of this document for a description of our eligibility requirements.

I-4 Who shall make all of the contributions to the Plan?

As your employer, we will make all of the contributions necessary to fund the Plan. If offered by your Employer, periodic interest credit may be applied to your bookkeeping account in an amount equal to the interest that you would have earned if your Plan balance had been held in an interest-bearing account. These notional interest credits would not be taxable, and like all other amounts accrued under this Plan, the notional interest accruals cannot be used for any purpose other than reimbursing Eligible Medical Expenses. You have no property rights in this reimbursement account. Please refer to Part A. "General Information About Your Plan" of this document for a description of our contribution schedule.

I-5. How much of my uninsured medical expenses may be reimbursed each year?

Please refer to Part A, "General Information About Our Plan," subsection (13), of this document for a description of the "Annual Limit" for our Plan. To the extent provided for in Part A, all or a portion of any unused amounts remaining at the end of the calendar year may be carried over for use in future periods in which you remain eligible under the Plan. Each Participant may also permanently opt out of and waive future reimbursements from the HRA at least annually, and upon termination of employment. However, upon opt out and waiver, any remaining amount in the HRA is forfeited.

I-6. How do I become a Participant?

Before you become a member or a "participant" in the Plan, there are certain rules which you must satisfy. First, you must meet the "eligibility requirements." Please refer to Part A, "General Information About Our Plan" of this document for a description of our eligibility requirements.

Once you have met the eligibility requirements, Please refer to Part A, "General Information About Our Plan" of this document for a description of our Entry Date.

I-7. How do I receive my benefits under the Plan?

When you incur an eligible medical or dental expense, you must submit a claim reimbursement request to the Plan's Administrator within the time frames specified under Part C, Section 2 set forth below. If the Plan Administrator determines that your claim is valid, you will be reimbursed for your eligible expenses as soon as is administratively feasible after it has been submitted. You may submit a claim for any eligible medical or dental expense arising during the Plan Year at any time during the period that begins when the expense is incurred. Remember, though, you can't be reimbursed for any total expenses above the annual amount of benefit the Company has provided plus any unused carryover amounts from the previous calendar year. If your claim arises while you have COBRA continuation coverage (see Answer I-17), all required premiums for the coverage (subject to a 30-day grace period for late payment of premiums) also must have been received by the Company prior to the request for reimbursement of otherwise allowable expenses.

To have your claims processed as soon as possible, please read the *Claims Instructions* that are available to you by the Plan Administrator. Please note that it is *not* necessary that you have actually paid an amount due for an eligible medical or dental expense—only that you have *incurred* the expense, and that it is not being paid for or reimbursed from any other source. For purposes of the Plan, you are considered to have "incurred" an expense when the health care services are rendered for which you are seeking a reimbursement, and not when you have actually paid the bill.

I.8. What happens if I receive overpayments or reimbursements are made in error from this Plan?

If it is later determined that you and/or your covered Dependent(s) received an overpayment or a payment was made in error (i.e., you were reimbursed for an expense under the Plan that is later paid for by some other medical plan), you will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment; or if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may include the amount on your W-2 as gross income. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this Plan (and to the extent permissible, under any applicable Employer group health plan).

In addition, you should also note that any previous benefit payments made from any Account under that Plan that are unclaimed (e.g., uncashed benefit checks) by the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

I-9. What is an "eligible expense?"

An "eligible expense" means any expense identified as an Eligible Medical Expense that is further described under subsection 12 of Part A, "General Information About our Plan" described above. However, you may not submit a claim for an amount that has been deducted on your prior year's personal tax return or that was incurred prior to the time that you became a participant under the Plan, nor shall you be entitled to submit a claim for any other expenses that have been paid through any other health insurance plan, Section 125 "cafeteria" plan, or other similar medical expense reimbursement arrangement. In addition, you may not submit a claim for medical expenses related to any over-the-counter (OTC) medicine or drug that is not prescribed or is not insulin. Please review the list of any other eligible medical expenses included with the *Claims Instructions* for assistance in determining what is generally accepted as an "eligible expense."

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean Section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or newborn earlier than 48 (or 96) hours. In any case, the Plan may not require a provider to obtain pre-authorization for a hospital stay in connection with childbirth not in excess of the applicable time period.

However, individually-owned health insurance policy premiums are not eligible expenses under this Plan.

I-10. When must the expenses be incurred that I may be reimbursed for?

Eligible expenses must have been incurred after the date the Plan became effective. You may not be reimbursed for any expenses arising before the Plan became effective, or prior to the time you became covered under the Plan, if later.

I-11. Does the Plan also provide benefits for my family?

The Plan provides reimbursement for expenses incurred for you, your spouse, and any other person you could claim as a dependent on your federal income tax return.

In addition, this Plan will cover a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under this Plan. The Plan Administrator of the medical plan will notify you if a medical child support order has been received. The Plan Administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan's QMCSO procedures. The Plan Administrator will notify both you and the affected child once a determination has been made. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting either the Plan Administrator of the medical plan or the Plan Administrator of this Plan (as identified in Part A General Information About Our Plan).

I-12. What happens if my claim for benefits is denied?

You will be notified in writing by the Plan's Administrator within 30 days of the date you submitted your claim if the claim is denied unless special circumstances require an additional 15 days to review the claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period. If you do not receive notification of the denial of a claim within the 30 day period, then if the claim is not otherwise paid, it will be deemed denied. The notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 180-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review. See Part C, subsection (4), below for more information regarding your rights to appeal any adverse claim determination.

I-13. Does my coverage under this Plan end when my employment terminates?

Generally yes. Your normal participation will cease at the end of the last day before your employment with the Company terminates. However, you may still receive reimbursement of any eligible expenses, as otherwise provided for under the Plan, as long as such reimbursement requests are made prior to the expiration of the run-out period described in Part A, General Information About Our Plan in the Summary Plan Description. In addition, you and your family will also have the opportunity to continue to be covered under the Plan under the terms of the Continuation Coverage provisions described in Answer I-17, below. Under all circumstances, coverage ends upon the earlier of your death or the date the Plan terminates.

I-14. Will my coverage end if I go on a family or medical leave under the FMLA?

Subject to certain conditions, the Family and Medical Leave Act ("FMLA") entitles you to take unpaid leaves of absence totaling 12 weeks per year for specific personal or family health and child care needs. Your coverage under the Plan will continue while you are on an FMLA leave as long as you opt to continue your coverage under the Plan and continue to make any applicable premium contributions that would otherwise be paid by your employer. Upon your return you will be

permitted to re-enter the Plan on the same basis that you were participating in prior to taking FMLA leave. However, you will lose coverage when you fail to return to work at the end of the leave or give earlier notice that you will not be returning to active employment.

I-15. Does my coverage continue while I am absent on duty in the uniformed services?

The Plan will continue to reimburse you or your family for eligible medical expenses (except for any illness or injury suffered by you in connection with duty in the uniformed services) for the first 30 days of your absence. However, coverage after that period will be suspended while you are on approved military service leave, unless you opt to continue coverage under the Plan in accordance with the procedures set forth in Answer I-17. No re-entry requirements will be imposed if you return to active employment within 30 days of taking leave of employment for duty in the uniformed services.

The "uniformed services" are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

I-16 Which Plan pays first if I am already enrolled in a Flexible Spending Account?

Please refer to Part A, "General Information About Our Plan" subsection (15) of this document to determine the Order of Benefit Payments option, if we provide the capability for you to participate in a Section 125 "Cafeteria" Flexible Spending Arrangement, in addition to this Plan.

If your Employer offers an HSA Program, with the exception of "limited benefits" that may be paid concurrently, any qualifying medical expense amounts that can be paid under the HSA Program must be exhausted before reimbursements can be made from the Health Reimbursement Arrangement. The Health Reimbursement Arrangement may then also reimburse employees for those costs that are not otherwise covered by the HSA or other provisions of the Plan.

I-17. What is "Continuation Coverage," and how does it work?

"Continuation Coverage" means your right, or your spouse and dependents' right, to continue to be covered under this Plan if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours below what is required for participation under this Plan.
- your death.
- divorce or legal separation from your spouse.
- your becoming entitled to receive Medicare benefits.
- when a dependent of yours ceases to be a dependent.

It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs. The notice of these rights that you will receive will explain all the rest of the terms and conditions of the continued coverage.

If you or any of your Eligible Dependents elect to continue coverage under the Plan, you or they will be required to pay premiums for the coverage. The Plan Administrator will inform you of the cost of continued coverage and the schedule for premium payments in the notice that will be sent to you and your Dependents after a Qualifying Event has occurred.

I-18. Are there any alternatives to "Continuation Coverage?"

You must be offered the chance to elect Continuation Coverage as described above; however, if you choose not to elect Continuation Coverage, you may choose the Spend-Down Option. The Spend-Down Option is designed to give you an alternative to Continuation Coverage. Under the Spend-Down Option, your Plan balance not used for expenses incurred prior to the Qualifying Event may be used for Eligible Medical Expenses incurred during the Spend-Down Period by you and/or your eligible Dependents. The Spend-Down Period begins on the date that you lose coverage under the Plan as the result of a Qualifying Event, and ends on the earlier of the date you spend your remaining balance in your reimbursement account, or the end of twelve (12) months from the date you lose coverage under the Plan as the result of a Qualifying Event. Any Plan funds not used for expenses incurred during the Spend-Down Period will be forfeited. Unlike Continuation Coverage, you will not be eligible for any future Employer contributions under the Spend-Down Option. You will receive information on how to elect the Spend-Down Option from your Continuation Coverage Administrator after you experience a Qualifying Event. You have the same period of time to elect the Spend-Down Option as you do to elect Continuation Coverage. If you elect the Spend-Down Option, you waive your right to Continuation Coverage; however, you may revoke this waiver any time during the 60 day Continuation Coverage election period. If you revoke your previous waiver of Continuation Coverage, Continuation Coverage will begin on the date of the revocation of the previous waiver—not the date of the Qualifying Event. If you elect Continuation Coverage, you forever lose your right to elect the Spend-Down Option.

I-19. How long will the Plan remain in effect?

Although the Company expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time.

This Plan may be amended or terminated by a written resolution adopted by a majority of the Company's Board of Directors. The Plan will also automatically terminate if the Company (1) is legally dissolved, (2) makes a general assignment for the benefit of its creditors, (3) files for liquidation under the Bankruptcy Code, (4) merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Company's successor in interest agrees to assume the liabilities under this Plan as to the Participants and Eligible Dependents. If the Plan is terminated, credits to your Accounts will be used to provide benefits through the end of the Plan Year in which termination occurs. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

PART C
ADDITIONAL PLAN INFORMATION

1. Plan Accounting

The Plan Administrator shall periodically furnish you with a statement of your medical and dental expense reimbursement account for you to use in determining how much additional benefits remain in your account prior to the end of the Plan Year, which will also assist in budgeting for expense reimbursement needs in future Plan Years. You may also make a written request to receive a copy of your medical and dental expense reimbursement account from the Plan Administrator at any time.

2. Claims Instructions

No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits to the Plan Administrator on a form specified by the Plan Administrator, or as otherwise set out below. Upon receipt of a properly documented claim, the Plan Administrator shall pay the Participant the benefits provided under this Plan as soon as is administratively feasible. A Participant may submit a claim for reimbursement for an Eligible Medical or Dental Expense arising during the Plan Year at any time during the period that begins when the expense is incurred.

The Participant may not submit a claim that is attributable any prior taxable year or any claim that was incurred before the individual became eligible for coverage under this Plan, or which has already been paid through any other health insurance plan, Section 125 "cafeteria" plan (including the Primary Care Holding Company Cafeteria Plan), or other similar medical expense reimbursement arrangement.

Two types of documentation are usually acceptable to the Plan Administrator as substantiation of any claim request:

First, you must submit your claims under any insurance plan under which the person receiving the medical service is covered - your own, your spouse's, and/or your dependent's health, dental, vision care, Medicare, etc. plans. This will result in the insurer sending an Explanation of Benefits (EOB). You may send the EOB as documentation of an unreimbursed out-of-pocket medical or dental expense. Second, for unreimbursed out-of-pocket medical or dental expense not covered by insurance and not documented by an EOB, you may submit a provider statement of the expenses, including: name of the recipient of the service; date of the service; description of the service; cost of the service; and name, address of the provider. You must also fill out a form provided to you by the Plan Administrator.

a) The Plan Administrator will process your claim, deduct the money from your Account, and send you a check in payment of your claim. The Plan Administrator issues checks as soon as reasonably practicable, but no less than monthly. If your claim request is denied, you will be notified of this denial under procedures further discussed and set forth below.

b) As an alternative to the method of payment referenced in subsection a) above, if an Eligible Employee agrees to the terms and conditions of any applicable cardholder agreement that provides for the payment of Eligible Medical Expenses through use of a debit card, credit card, other stored value card or other similar electronic media (hereinafter the "Debit Card"), payments under this Plan shall be made directly to the service provider, authorized merchant or other independent third party that provides products or services that are eligible for payment of Eligible Medical Expenses as otherwise set forth herein.

    (i) Within the cardholder agreement, the Eligible Employee agrees that payment for Eligible Medical Expenses can only be made on behalf of the Employee, the Employee's spouse or other qualifying dependents and is otherwise limited to the maximum dollar amount of coverage that is otherwise specified for that Benefit in accordance with the limitations set forth in the Employer's signed Adoption Agreement or as otherwise specified by the Employee's signed Election. The Employee also certifies that any expense paid with the card has not been, and will not be, reimbursed through any other plan or method of coverage provided under this Plan. The cardholder also understands that the certification, which shall be printed on the back of the Debit Card, is reaffirmed each time the card is used. The cardholder also agrees to acquire and retain sufficient documentation for any expense(s) paid with the card, including invoices and receipts where appropriate or as required by law. The cardholder also understands that the Debit Card is automatically cancelled upon ceasing to participate in the Plan, or under such other situations that are otherwise set forth within the cardholder agreement itself.

    (ii) Unless other more stringent procedures or requirements are implemented and communicated to the Employer and its Employees, the Administrator agrees that it shall adhere to the terms and conditions of any separate Employer cardholder servicing agreement, including but not limited to a requirement to maintain the program in compliance with applicable standards under the Internal Revenue Code and any mandates that payments for Eligible Medical Expenses only be made to

authorized merchants and service providers. The Administrator also agrees that it shall establish and maintain procedures for substantiation of any payments after the card has been used for Eligible Medical and Dental Expense payments that are in accordance with applicable provisions of the Code, any underlying Regulations and other applicable guidance thereunder.

(iii) If any claim reimbursement request is being submitted in a manner other than as specified under any of the methods allowable under existing IRS guidelines, the Administrator may make a conditional payment of an allowable Eligible Medical and Dental Expense reimbursement item to the authorized service provider, merchant, or approved independent third party, but shall also require the cardholder to remit additional third-party information, such as merchant or service provider receipts, describing the service or product; the date of service or sale; and the amount, which shall be subject to further review and substantiation.

(iv) If any conditional payment has been made but is subsequently deemed not to be an Eligible Medical Expenses reimbursement, the Administrator shall ensure that proper correction procedures are maintained with respect to the improper payment(s):

(A) Upon identification of any improper payment, the Administrator shall require the Employee to pay back to the Plan an amount equal to the improper payment;

(B) If the Employee does not immediately repay the Plan, the Administrator shall ensure that the proper amount is withheld from the Employee's wages or other compensation (with such amounts then being immediately remitted to the Plan by the Employer) to the extent consistent with applicable law;

(C) To the extent that neither (A) or (B) above are allowable or effective, the Administrator shall have the authority to utilize a claim substitution or offset approach to resolve the improper claim amount(s), with such methodology being clearly explained to the Employee-cardholder as part of his Employee cardholder agreement.

(D) The Administrator may also take any further steps or actions as deemed necessary, including denial or cancellation of access to the debit or credit card until the indebtedness is repaid by the Employee. The Administrator may also pursue any other methods of collection as would be consistent with its usual business practices to ensure the improper payment amounts are adequately remitted to the Plan as required by the Plan or Employee cardholder agreement.

(v) If a cardholder attempts to utilize the Debit Card for any improper or non-allowable purpose, the Participant/cardholder shall be responsible for any and all fees or other expenses, including restitution or other similar penalty amounts, charged inappropriately by the Participant/cardholder.

3. Your Rights under ERISA

As a Plan Participant, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA") to the extent the Employer is subject to COBRA as set forth in the relevant Code, Employees Retirement Income Security Act of 1974 ("ERISA"), and/or Public Health Safety Act ("PHSA") statutory provisions and the applicable regulations promulgated thereunder.. ERISA provides that all Plan participants shall be entitled to:

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of this Plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have an affirmative duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the Plan or exercising your rights under ERISA.

If your claim for a benefit under this Plan is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration, (800) 998-7542.

4. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than the run-out period described in the "General Information About Our Plan". Any claims submitted after that time will not be considered. Claims for benefits that are insured will be received in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include:

a) Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
b) The reasons for the denial;
c) Reference to the specific provisions of the Plan on which the denial was based;
d) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
e) A description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
f) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;

g) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request;

h) The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

You or your beneficiary shall have 180 days following the receipt of any notification of Claim denial to appeal the decision, making a written request for reconsideration to the Administrator. Documents, comments, records or any other information in support of your appeal should be submitted in writing and accompany any such request. You or your beneficiary may review pertinent documents and receive copies of all documents and records, free of charge. You will be provided any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial of your Claim. You will have a reasonable opportunity to respond to such new evidence or rationale.

The Administrator will review the Claim, without deference to the initial denial and after taking into account all comments, information, documents, records and other information submitted as part of the appeal. Unless a 15-day written extension is utilized to review further information, the Administrator will provide a written response to the appeal within 30 days from the date of receipt of any appeal request. In this response, the Administrator will explain the reason for the decision, with reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to review and interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding.

In the event you receive notice of an adverse benefit determination, you may file with the Plan a request for an external review of your Claim, but only if the request for a review involves a claim denied either for medical judgment (for example, medical necessity), or a rescission of coverage. Medical judgment is determined by the external reviewer, who makes the ultimate determination as to whether a claim is eligible for external review. Please contact the Plan Administrator for additional information about external claims procedures.

5. Non-Discrimination Requirements

To the extent that the Plan is treated as a self-insured medical expense Plan under Reg. Section 1.105-11, it must comply with the non-discrimination requirements as set forth under Section 105(h).

6. Highly Compensated Employees

Under the Internal Revenue Code, if you are deemed to be a "highly compensated employee", the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Your own circumstances will dictate whether contribution limitations on "highly compensated employees" will apply. You will be notified of these limitations if you are affected.

7. No Employment Rights Conferred

Neither this Plan nor any action taken with respect to it shall confer upon any person the right to be continued in the employment of the Employer.

8. HIPAA Privacy

Title II of the Health Insurance Portability and Accountability Act of 1996 and the regulations at 45 CFR Parts 160 through 164 ("HIPAA"), contain provisions governing the use and disclosure of Protected Health Information by health plans, and provide privacy rights to participants in those plans. HIPAA applies to this Plan.

Protected Health Information or "PHI" is health information that is created or received by the Plan. PHI relates to your physical or mental health or condition, the provision of health care to you, or the payment for the provision of health care to you. Typically, the information identifies you, your diagnosis, and treatment or supplies used in the course of your treatment. Electronic Protected Health Information (also known as "ePHI") is PHI stored in any electronic media, including any memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card or the transmission or exchange of information through usage of the internet

(wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/ transportable electronic storage media, but does not include facsimile or voice transmissions and is limited to the information created, maintained, transmitted or received by or on behalf of the Plan.

The Plan may disclose PHI to the Employer only for limited purposes as described in the Plan's documents. The Employer agrees to use and disclose PHI only as permitted or required by the Plan's documents or as required by HIPAA. PHI or ePHI may be used or disclosed for plan administration functions that the Employer performs on behalf of the Plan. Such functions include:

- Enrollment of eligible employees and their eligible dependents
- Eligibility determinations
- Payment for coverage
- Claim payment activities
- Coordination of benefits
- Claim appeals

In order to perform these functions, the Plan will use and disclose PHI only to the following individuals:

- Human Resources Director
- HIPAA Privacy Official
- Other Personnel, specifically designated by the Plan's Privacy Official

The Plan shall maintain policies and procedures that govern the Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the above individuals and only for the functions listed above. The Plan's policies and procedures also include a mechanism for resolving issues of noncompliance. A notice has been provided to you summarizing the Plan's policies and procedures.

PART D
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our goal with the Plan is to allow you to have a greater portion of your allowable medical expense costs reimbursed to you without increasing the amount of taxes you pay; thereby increasing the amount of money you keep at the end of each pay period. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Attachment A

*** VERY IMPORTANT NOTICE ***
(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES)
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

INTRODUCTION

A federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

CONTINUATION COVERAGE FOR EMPLOYEE (COBRA)

If your employer is subject to COBRA, you, as an employee of that employer, have the right to continue coverage under your current Plan if your coverage is lost due to any of the following qualifying events:

1.1 QUALIFYING EVENTS

1. Termination of employment (for reasons other than gross misconduct.)

2. Involuntary termination of employee.

3. Reduction in hours of employment.

CONTINUATION COVERAGE FOR SPOUSE OF EMPLOYEE

As a spouse of a covered employee, you have the right to continue coverage under your current health plan(s) if your coverage is lost due to any of the following qualifying events:

1.2 QUALIFYING EVENTS

1. A termination of your spouse's employment (for reasons other than gross misconduct).

2. Reduction in your spouse's hours of employment.
3. The death of your spouse.

4. Divorce or legal separation from your spouse.

5. Your spouse becomes entitled to Medicare.

CONTINUATION COVERAGE FOR DEPENDENT OF EMPLOYEE

As a dependent child of a covered employee, you have the right to continue your current coverage if your coverage is lost due to any of the following qualifying events:

1.3 QUALIFYING EVENTS

1. The termination of an employee parent's employment (for reasons other than gross misconduct).

2. Reduction in an employee parent's hours of employment with his/her current employer.

3. The death of your employee parent.

4. Parent's divorce or legal separation.

5. Employee parent becoming entitled to Medicare.

You cease to be a "dependent child" under the current health plan(s).

1.4 NOTIFICATION AND PREMIUMS

Under this law, it is your responsibility to inform us of a divorce, legal separation, or a child losing dependent status under the plan(s) within 60 days of the occurrence of the event. You must also notify us within 60 days of receiving a disability determination letter from the Social Security Administration. Upon the occurrence of a qualifying event, you will be notified of your right to continue coverage under your current health plan(s). If you elect continuation coverage you must do so, in writing, within 60 days from the later of the notice or the date of the qualifying event/loss of coverage.

The recipient of coverage may have to pay part or all of the cost of coverage, which cannot exceed 102 percent of the cost under the group plan. If, during the continuation period, rates change for the employer group, persons under COBRA are subject to that increase.

You will have a 45-day period from the date you elect continuation coverage to pay the initial premium. This premium must include the entire amount due from the date you would have lost coverage to the date of the election. Thereafter, you will be given a grace period of not less than 30 days to pay premiums.

If you choose continuation coverage, your employer is required to give you coverage that is identical to the coverage provided under the plan to similarly situated employees or family members.

You do not have to show that you are insurable to choose continuation coverage.

If you do not choose continuation coverage, your group health coverage will end as of the date of the qualifying event.

If a qualified beneficiary dies or becomes incapacitated during the election period, he or she may not be able to elect coverage timely. A legally appointed guardian can make the election and act for the qualified beneficiary. However, there may not be adequate time during the 60-day election period. Therefore, the election period can be extended until a legally appointed guardian is designated. This extension of the time period is referred to as "tolling".

1.5 TERMINATION OF RIGHTS

If you do choose continuation coverage, the law provides that coverage may be terminated for any of the following reasons:

1. Your employer terminates all group health coverage provided to its employees.

2. The premium for your continuation coverage is not paid in full the time prescribed under the Notifications and Premiums section of this notice.

3. You are or become covered under another group health plan other than the plan of the employer providing continuation as long as no exclusionary period will be imposed on a preexisting condition.

4. You are or become entitled to Medicare. However, if it is determined that Medicare is to be the secondary payor, your continuation coverage under your current health plan(s) is primary until Medicare becomes primary, or continuation coverage is otherwise terminated, whichever is earlier.

1.6 ADDITIONAL INFORMATION

If you have questions about your right to continue coverage under your current health plan(s), please contact your Plan Administrator.

If you change your address, marital status, or become entitled to Medicare or another group health plan while you are covered under the plan, please notify your Plan Administrator.

1.7.1 QUALIFIED BENEFICIARIES

The term Qualified Beneficiary (Q.B.) refers to individuals who are covered under the employee's group health plan the day before a COBRA qualifying event takes place. According to the COBRA statutes, a Qualified Beneficiary is the covered employee, covered spouse of the employee, covered dependent child of the employee **OR** any child born to, or placed for adoption with the covered employee during the period of continuation coverage.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose.

This notice is intended to inform you of the privacy practices followed by your employer and other affiliated entities (the "Employer"), which provide a group health plan to eligible employees under the Health Reimbursement Arrangement (the "Health Plan" or "Plan"). It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group health plan.

As a plan sponsor, your employer may need access to health information in order to perform plan administrator functions. We want to assure the plan participants covered under our group health plan that we comply with federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information comply with the privacy practices outlined below.

Uses and Disclosures of Health Information.

Health Care Operations. We use and disclose health information about you in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g. preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you $0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, health care operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Requirements. We are required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, or if you have any questions or complaints, please contact your plan administrator.

Filing a Complaint. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information.