Health Reimbursement Arrangement
Plan Document

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Health Reimbursement Arrangement Plan Document

ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

_____ hereby establishes a self-funded Health Reimbursement Arrangement (HRA) Plan (the "Plan") to be effective as of the Effective Date specified in Section 2.1(f) below.

This Plan is intended to permit an Eligible Employee to obtain reimbursement of Eligible Medical or Dental Expenses on a nontaxable basis from such Employee's HRA Account.

1.2 Legal Status

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code Section 105 and Code Section 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Eligible Medical or Dental Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b).

ARTICLE II. DEFINITIONS

2.1 Definitions

(a) **"Adoption Agreement"** means the separate agreement adopting the Employer's Plan, attached hereto and incorporated by reference herein.

(b) **"Benefits"** means the reimbursement benefits for Eligible Medical or Dental Expenses set forth in Article V and as specifically described in the Adoption Agreement.

(c) **"Code"** means the Internal Revenue Code of 1986, as amended.

(d) **"Covered Individual"** means, for purposes of Article VI, a Participant, Spouse or Dependent.

(e) **"Dependent"** means any individual who is a tax dependent of a Participant as defined in Code § 105(b), with the following exception: any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

(f) **"Effective Date"** means the Effective Date as set forth in the Employer's Adoption Agreement.

(g) **"Electronic Protected Health Information"** has the meaning described in 45 C.F.R. 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic format. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment or disenrollment information and summary health information.

(h) **"Eligible Employee"** means an Employee eligible to participate in this Plan, as provided in Section 3.1.

(i) **"Eligible Medical or Dental 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 V, and are otherwise allowable as deductions under Code Section 213 (without regard to the limitations contained in Code Section 213(a)). 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:

- an illness or injury (or aggravation of an illness or injury) incurred by an Employee during a period of duty with the Uniformed Services;
- a medical expense incurred before the Employee first becomes enrolled in the Plan; or
- medical expenses incurred before the Plan is in existence.

(j) **"Employee"** means an individual who meets the requirements as described Section 3.1 as being eligible to participate in this Plan. The term "Employee" does not include the following: (a) any self-employed individual as defined in Code Section 401(c); (b) any partner in a partnership and (c) any more-than-2% shareholder in a Subchapter S corporation, including those deemed to be a more-than-2% shareholder by virtue of the Code Section 318 ownership attribution rules.

(k) **"Employer"** means _____ or any successor thereof that adopts this Plan pursuant to the terms of the Employer's Adoption Agreement. The Plan Sponsor retains sole authority as Plan Administrator for all purposes under the Plan (and in accordance with the provision of Article VIII) and retains sole authority to amend or terminate the Plan in accordance with Section 9.2.

(l) **"Entry Date"** means the Plan Entry Date set forth in the Employer's Adoption Agreement.

(m) **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended.

(n) **"Health FSA"** means a health flexible spending arrangement as defined in Proposed Treasury Reg. Section 1.125-2, Q/A 7(a).

(o) **"Health Insurance Plan"** means the individual or association group health insurance policies or plan(s) purchased by and covering Eligible Employees, including those policies or plans that may be sponsored or recommended by the Employer.

(p) **"Highly Compensated Individual"** means an individual defined under Code Section 105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

(q) **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended.

(r) **"HRA"** means a health reimbursement arrangement as defined in IRS Notice 2002-45.

(s) **"HRA Account"** means the HRA Account described in Section 5.4.

(t) **"Participant"** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

(u) **"Period of Coverage"** means the Plan Year, during which period the Benefits provided by this Plan shall be available to a Participant hereunder, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year

prior to the date participation terminates, as described in Section 3.2. A different Period of Coverage (e.g., monthly) may be established by the Plan Administrator and communicated to Participants.

(v) **"Plan"** means this instrument, including all amendments and attachments thereto.

(w) **"Plan Administrator"** means the Plan Sponsor identified in the Employer's Adoption Agreement or any person or other third party appointed by the Plan Sponsor who has the authority and responsibility to manage and direct the operation and administration of the Plan.

(x) **"Plan Year"** means the annual accounting period of the Plan as set forth in the Employer's Adoption Agreement.

(y) **"Protected Health Information"** shall have the meaning described in 45 C.F.R. 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

(z) **"QMCSO"** means a qualified medical child support order, as defined in ERISA Section 609.

(aa) **"Spouse"** means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code). Spouse shall not include an individual separated from the Participant under a legal separation decree.

(bb) **"SPD"** means the separate summary plan description describing the terms of this Plan.

(cc) **"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.

(dd) **"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

Any individual who is a bona fide Employee of the Employer who is regularly scheduled to work five (5) or more hours per week shall be eligible to participate in the Plan on the Entry Date specified in the Employer's Adoption Agreement (or the Effective Date of the Plan, if later).

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the termination of this Plan; or
- the date on which the Participant ceases (because of termination of employment, reduction in hours, or any other reason) to be an Eligible Employee.

Reimbursements from an HRA Account after termination of participation will be made pursuant to Section 5.7.

3.3 Termination of Participation for an Eligible Spouse or Dependent

A Participant's Spouse's or Dependent's coverage shall terminate:

- upon the occurrence of any of the events set forth in Section 3.2 with respect to the Participant; or
- when an individual no longer qualifies as a Spouse or Dependent eligible to participate in this Plan.

3.4 Participation Following Termination of Employment or Loss of Eligibility

If a Participant's employment terminates for any reason, including (but not limited to) disability, layoff or voluntary resignation, and the Participant is rehired within 30 days or less of the date of the termination of employment, the Participant will be reinstated with the same HRA Account balance that such individual had immediately before termination. If an Employee (whether or not a Participant) terminates employment and is not rehired within 30 days or ceases to be an Eligible Employee for any other reason, including (but not limited to) a reduction in hours, and then becomes an Eligible Employee again, the Employee may begin participating in the Plan as of the Entry Date specified in the Employer Adoption Agreement.

3.5 Non-USERRA Leaves of Absence

If a Participant goes on a leave of absence that is not subject to USERRA, the Participant will be treated as having terminated participation, as described above under Section 3.2, to the extent provided for in the Employer's Adoption Agreement. A Participant's leave of absence subject to USERRA shall be governed by the provisions set forth in Section 5.10.

3.6 Certificates of Creditable Coverage

The Plan normally will provide a Certificate of Creditable Coverage to any Participant, Spouse or Dependent automatically after the individual loses coverage under the Plan. In addition, a Certificate of Creditable Coverage 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 of Creditable Coverage 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 of Creditable Coverage will contain the following information:

- The date the Certificate of Creditable Coverage was issued;
- The name, if known, of the insurance carrier that issued the health insurance policy or plan to the Eligible Employee;
- The name of the Participant, Spouse or Dependent to whom the certificate applies;
- The name, address, and telephone number of the Plan Administrator or issuer providing the certificate;
- A telephone number for further information (if different);
- Either (i) a statement that the Participant, Spouse or Dependent has at least 18 months of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage (i.e., a period of 63 or more consecutive days during all of which an individual did not have any Creditable Coverage, exclusive of waiting periods); or (ii) the date any waiting period began and the date Creditable Coverage began; and
- The date Creditable Coverage ended, unless the Certificate of Creditable Coverage indicates that coverage is continuing as of the date of the Certificate.

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

For purposes of this Section 3.7, "Certificate of Creditable Coverage" means a written certificate of the period of creditable coverage of the individual under the Plan, and the waiting period (if any) imposed with respect to the individual for any coverage under this Plan. "Creditable Coverage" means prior medical coverage that an individual had from any of the following sources: a) this Plan, b) health insurance coverage, c) Medicare, d) Medicaid, e) medical and dental care for members and former members of the Uniformed Services and their dependents, f) a medical care program of the Indian Health Service or a tribal organization, g) a state health benefits risk pool, h) 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, i) a health plan offered under the Federal Employees Health Benefits Program, j) a public health plan or k) a health benefit plan under the Peace Corps Act.

ARTICLE IV. BENEFITS OFFERED AND METHOD OF FUNDING

4.1 Description of Benefits Offered

When an Eligible Employee becomes a Participant in accordance with Article III, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Eligible Medical or Dental Expenses, as described in Article V. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Medical or Dental Expenses.

Each Participant shall be entitled to reimbursement for his documented Eligible Medical or Dental Expenses incurred during the Plan Year in an annual amount not to exceed the amount specified in the Employer's Adoption Agreement and in accordance with the payment ordering rules set forth in Section 5.9, which determine whether benefits are paid under this Plan before or after some other plan or reimbursement arrangement. The maximum dollar limit for reimbursements may be changed by the Plan Administrator in subsequent Plan Years and shall be communicated to Employees through the SPD or other document.

To the extent a Participant has an Available Amount, as defined in Section 5.4(c) at the end of any plan year, such Participant is entitled to carryover all of such Available Amount 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.

4.2 Employer and Participant Contributions

(a) Employer Contributions. The Employer funds the full amount of the HRA Accounts.

(b) Participant Contributions. There are no Participant contributions for Benefits under the Plan.

(c) No Funding Under Cafeteria Plan. Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employer contributions to the Plan.

4.3 Funding of the Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

ARTICLE V. HEALTH REIMBURSEMENT BENEFITS

5.1 Benefits

The Plan will reimburse Participants for Eligible Medical or Dental Expenses up to the unused amount in the Participant's HRA Account, as set forth and adjusted under Section 5.4.

Each Participant in the Plan shall be entitled to a Benefit hereunder for all Eligible Medical and Dental 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 this Article V, regardless of 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.

5.2 Eligible Medical or Dental Expenses

Under the HRA Account, a Participant may receive reimbursement for Eligible Medical or Dental Expenses incurred during a Period of Coverage.

Eligible Medical or Dental Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Insurance Plan, other insurance, or any other accident or health plan (see Section 5.9 if the other health plan is a Health FSA). If only a portion of Eligible Medical or Dental Expenses has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), the HRA Account can reimburse the remaining portion of such Eligible Medical or Dental Expenses if it otherwise meets the requirements of this Article V.

5.3 Nondiscrimination Requirements

To the extent that the Plan is considered a self-insured medical expense plan under Treasury Regulation Section 1.105-11, the Plan must comply with the nondiscrimination requirements as set forth under Code Section 105(h). Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code Section 105(h), as may be determined by the Plan Administrator in its sole discretion.

5.4 Establishment of HRA Account

The Plan Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) Crediting of Accounts. A Participant's HRA Account will be credited at the beginning of each period as set forth in the Employer's Adoption Agreement with the applicable dollar amount (as elected by the Employer in the Adoption Agreement), increased by any carryover of unused Account balance from a prior Period(s) of Coverage, as allowed in Sections 4.1, and 5.5.

(b) Debiting of Accounts. A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Eligible Medical or Dental Expenses incurred during the Period of Coverage.

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

5.5 Carryover of Accounts

If any Available Amount remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the Participant for Eligible Medical or Dental Expenses incurred during a subsequent Period of Coverage.

Any Plan Benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Eligible Medical or Dental Expense was incurred shall be forfeited.

5.6 Reimbursement Procedure

(a) General Requirements. 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 and pursuant to the procedures set forth 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 Period of Coverage 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.

A Participant may not submit a claim that is attributable to a deduction under Code 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

All reimbursement claims must be submitted to the Plan Administrator within 60 days of the close of the Plan Year during which any such expense was incurred in order to be eligible for reimbursement.

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

(c) Claims Substantiation. A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, setting forth:

- the person or persons on whose behalf Eligible Medical or Dental Expenses have been incurred;
- the nature and date of the expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage (if applicable as determined under Section 5.9), for such expenses has been exhausted.

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

(d) Claims Denied. For reimbursement claims that are denied, see the appeals procedure in Article VII.

5.7 Reimbursements After Termination of Employment or Failure to Satisfy the Plan's Eligibility Requirements

Coverage under this Plan shall cease immediately upon any one of the following events:

(a) A Participant is no longer employed by the Employer; or

(b) A 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 incurred during the Period of Coverage while the Participant was covered under the Plan at any time prior to the expiration of the earlier of: 1) 30 days following the date the Participant ceased his or her employment or eligibility; or 2) the end of the 60 day period following the close of the Plan Year in which the expense was incurred.

5.8 Named Fiduciary; Compliance With ERISA, HIPAA, etc.

(a) Named Fiduciary. The named fiduciary for the Plan for purposes of ERISA Section 402(a) shall be _____.

5.9 Coordination of Benefits; Health FSA to Reimburse First

Unless the Employer's Adoption Agreement specifies that Eligible Medical or Dental Expenses under a Code Section 125 Health Care Flexible Spending Account (Health FSA) must be reimbursed first before this Plan, if coverage for an Eligible Medical or Dental Expense is provided under both a Health FSA and the Plan, then the amounts available under the Plan must be exhausted before reimbursements can be made from the Health FSA. The Health FSA may then reimburse Employees for those costs that are not covered by the Plan.

5.10 USERRA

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, then to the extent required by USERRA, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Employee. No reentry eligibility requirements will be imposed on any Participant who returns to active employment with the Employer within 30 days of completing a period of absence from employment with the Employer for duty in the Uniformed Services.

ARTICLE VI. HIPAA PRIVACY AND SECURITY

6.1 Employer's Certification of Compliance

The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 CFR 164.504(f)(2)(4), and that the Employer agrees to conditions of disclosure set forth in this Article VI.

6.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Employer information on whether an individual is participating in the Plan.

6.3 Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

"Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

6.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by the Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Article VI (including, but not limited to, the restrictions on the Employer's use and disclosure described in 6.5) and the specifications and requirements of the Administrative Simplification provisions of Title II, Subtitle F of HIPAA and its implementing regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64.

6.5 Restrictions on Employer's Use and Disclosure of Protected Health Information

(a) The Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.

(b) The Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to the Employer with respect to the Protected Health Information or Electronic Protected Health Information, respectively.

(c) The Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Employer.

(d) The Employer will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Employer becomes aware.

(e) The Employer will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 C.F.R. 164.524.

(f) The Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 C.F.R. 164.526.

(g) The Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 C.F.R. 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528.

(h) The Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the Plan available to the Plan and to the United States Department of Health and Human Services to determine compliance with the HIPAA as set forth in 45 C.F.R. Part 164, Subpart E.

(i) The Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, the Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(j) The Employer will ensure that there is an adequate separation between the Plan and the Employer (i.e., the "firewall"), as required in 45 CFR 504(f)(2)(iii).

6.6 Adequate Separation Between Employer and the Plan

(a) Only the employees or classes of employees or other workforce members under the control of the Employer who are specified in the Employer's Adoption Agreement may be given access to a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan or a business associate servicing the Plan.

(b) The employees, classes of employees or other workforce members identified in Section 6.6(a), above, will have access to a Covered Individual's Protected Health Information or Electronic Protected Health Information only to perform the plan administration functions that the Employer provides for the Plan.

(c) The employees, classes of employees or other workforce members identified in Section 6.6(a), above, will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of this Article VI.

6.7 Security Measures for Electronic Protected Health Information

The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of a Covered Individual's Electronic Protected Health Information that the Employer creates, receives, maintains, or transmits on the Plan's behalf.

6.8 Notification of Security Incident

The Employer will report to the Plan any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in the Employer's information systems, of which the Employer becomes aware.

ARTICLE VII. APPEALS PROCEDURE

7.1 Procedure If Benefits Are Denied Under This Plan

Any claim for Benefits shall be made to the Plan Administrator. If the Plan Administrator denies a claim, the Plan Administrator shall provide notice to the Participant or beneficiary, in writing, within 30 days after the claim is filed. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including cases where a reimbursement claim is incomplete. If the Plan 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 the denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

- The reason(s) for the denial;
- Specific reference to the provisions of the Plan on which the denial was based;
- 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;
- A description of the Plan's review procedures and time limits applicable to such procedures, as well as the Participant's right to bring a civil action under Section 502 of ERISA following a final appeal;
- 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;
- 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.

7.2 Right to Request Hearing on Benefit Denial

When the Participant receives a denial of a claim, 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 relevant 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 review of a claim denial 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:

- was relied upon in making the claim determination;
- 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;
- 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
- 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.

7.3 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, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than one hundred-twenty (120) days after receipt of a request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial sixty (60) day period. 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 or her right to legal remedies set forth in Section 7.4.

7.4 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.

ARTICLE VIII. RECORDKEEPING AND PLAN ADMINISTRATION

8.1 Plan Administrator

Except as to the functions reserved within the Plan or the Employer's Adoption Agreement to the Employer's board of directors (the "Board"), the administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out in accordance with its terms for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

8.2 Powers of the Plan Administrator

The Plan Administrator shall have such authority and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right (except as to matters reserved to the Board or which the Board may reserve to itself) to interpret the Plan and to decide all matters thereunder, including the right to remedy possible ambiguities, inconsistencies or omissions. All determinations of the Plan Administrator 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 authority:

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

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

(c) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan and as a condition to receiving any Benefits under the Plan;

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

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

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

(g) 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;

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

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

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

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

8.3 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Board if required in the Employer's Adoption Agreement, 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 to taken or permitted shall be conclusive and binding as to all persons.

8.4 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of this Plan.

8.5 Compensation of Plan Administrator

Unless otherwise determined by the Board and permitted by law, the Plan Administrator shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of its duties shall be paid by the Employer.

8.6 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.

8.7 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 or her HRA Account unless otherwise paid by the Employer.

8.8 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan; and (b) 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 be retained by, the Employer.

8.9 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.

8.10 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.

8.11 Periodic Account Statements

The Plan Administrator shall, on a periodic basis, provide each Participant with a statement of his or her HRA Account balance, as well as provide a copy of such information to any Participant who makes a specific written request.

8.12 Inability to Locate Payee

If elected in the Employer's Adoption Agreement, 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 it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

8.13 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code Section 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the Plan.

ARTICLE IX. GENERAL PROVISIONS

9.1 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

9.2 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Board or by any person or persons authorized by the Board to take such action.

9.3 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of Texas, to the extent not superseded by the Code, ERISA or any other federal law.

9.4 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

9.5 Relationship to a Cafeteria Plan

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

9.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

9.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

9.8 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.

9.9 Mental or Physical Incompetence

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 9.9 shall completely discharge the Plan Administrator and the Employer.

9.10 Payments to Beneficiary

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

9.11 Non-Assignability of Rights

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

9.12 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and shall not be construed as defining or limiting the meaning or construction of any provision.

9.13 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

9.14 Severability

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