REQUEST FOR AGENDA PLACEMENT FORM

Submission Deadline - Tuesday, 12:00 PM before Court Dates

SUBMITTED BY: Randy Gillespie **TODAY'S DATE:** October 18, 2022

DEPARTMENT: Personnel

SIGNATURE OF DEPARTMENT HEAD: Randy Gillespie

REQUESTED AGENDA DATE: October 24, 2022

SPECIFIC AGENDA WORDING:

Consideration of adoption of Johnson County's Health Reimbursement Arrangement Basic Plan Document and Summary Plan Description which will be administrated by Alerus; and, authorization for County Judge to sign the Certificate of Adopting Resolution for such Health Reimbursement Arrangement.

COMMISSIONERS COURT

OCT 24 2022

Approved

PERSON(S) TO PRESENT ITEM: Randy Gillespie

SUPPORT MATERIAL: (Must enclose supporting documentation)

TIME: 5 mins
(Anticipated number of minutes needed to discuss item)

ACTION ITEM: ✔
WORKSHOP:
CONSENT:
EXECUTIVE:

STAFF NOTICE:

COUNTY ATTORNEY: ✔
AUDITOR:
PERSONNEL:
BUDGET COORDINATOR:

IT DEPARTMENT:
PURCHASING DEPARTMENT:
PUBLIC WORKS:
OTHER:

This Section to be completed by County Judge's Office

ASSIGNED AGENDA DATE: _____

REQUEST RECEIVED BY COUNTY JUDGE'S OFFICE:

_____ _____

COURT MEMBER APPROVAL: **DATE:**

CERTIFICATE OF ADOPTING RESOLUTION

The undersigned authorized representative of Johnson County (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer on October 1, 2022, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the Health Reimbursement Arrangement effective October 1, 2022, presented to this meeting is hereby approved and adopted and that an authorized representative of the Employer is hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

The undersigned further certifies that attached hereto is a true copy of the Health Reimbursement Arrangement and the Summary Plan Description which are hereby approved and adopted.

Date: 10-24-22

Signed: Roger Harmon

Roger Harmon County Judge
[print name/title]

HEALTH REIMBURSEMENT ARRANGEMENT

BASIC PLAN DOCUMENT

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HEALTH REIMBURSEMENT ARRANGEMENT

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

ARTICLE I
DEFINITIONS

1.1 "Administrator" means the Employer or the person or persons designated by the Employer to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 "Adoption Agreement" means the separate agreement which is executed by the Employer and sets forth the elective provisions of this Arrangement as specified by the Employer.

1.3 "Affiliated Employer" means any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

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

1.5 "Coverage Period" means the time period as set forth in the Adoption Agreement.

1.6 "Dependent" means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). Any child of a Participant who is an "alternate recipient" under a qualified medical child support order shall be considered a Dependent under this Plan.

Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law as amended from time to time.

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

The phrase "placed for adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation

for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.7 "Effective Date" means the date specified in the Adoption Agreement.

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

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

1.9 "Employee" means any person who is employed by the Employer. The term "Employee" shall also include any person who is an employee of an Affiliated Employer and any Leased Employee deemed to be an Employee as provided in Code Section 414(n) or (o).

1.10 "Employer" means the entity specified in the Adoption Agreement, any successor which shall maintain this Plan and any predecessor which has maintained this Plan. In addition, unless the context means otherwise, the term "Employer" shall include any Participating Employer which shall adopt this Plan.

1.11 "Employer Contribution" means the amounts contributed to the Plan by the Employer.

1.12 "Leased Employee" means any person (other than an Employee of the recipient Employer) who, pursuant to an agreement between the recipient Employer and any other person or entity ("leasing organization"), has performed services for the recipient (or for the recipient and related persons determined in accordance with Code Section 414(n)(6)) on a substantially full time basis for a period of at least one year, and such services are performed under primary direction or control by the recipient Employer. Contributions or benefits provided a Leased Employee by the leasing organization which are attributable to services performed for the recipient Employer shall be treated as provided by the recipient Employer. Furthermore, Compensation for a Leased Employee shall only include Compensation from the leasing organization that is attributable to services performed for the recipient Employer.

A Leased Employee shall not be considered an employee of the recipient Employer if: (a) such employee is covered by a money purchase pension plan providing: (1) a nonintegrated employer contribution rate of at least ten percent (10%) of compensation, as defined in Code Section 415(c)(3), including amounts contributed pursuant to a salary reduction agreement which are excludable from the employee's gross income under Code Sections 125, 402(e)(3), 402(h)(1)(B), 403(b), or 132(f)(4), (2) immediate participation, and (3) full and immediate vesting; and (b) leased employees do not constitute more than twenty percent (20%) of the recipient Employer's nonhighly compensated workforce.

1.13 "Participant" means any Eligible Employee who has satisfied the requirements of Section 2.1 and has not for any reason become ineligible to participate further in the Plan.

1.14 "Plan" means this Basic Plan Document and the Adoption Agreement as adopted by the Employer, including all amendments thereto. "Plan" means the "Health Reimbursement Arrangement."

1.15 "Premiums" mean the Participant's cost for any health plan coverage.

1.16 "Qualifying Medical Expenses" means any expense eligible for reimbursement under the Health Reimbursement Arrangement which would qualify as a "medical expense" (within the meaning of Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder) incurred by the Participant, the Participant's Spouse or a Dependent and not otherwise used by the Participant as a deduction in determining the Participant's tax liability under the Code or reimbursed under any other health coverage, including a health Flexible Spending Account. Qualifying Medical Expenses covered by this Plan are limited as elected in the Adoption Agreement. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c). If the Employer provides Health Savings Accounts for Participants, Qualifying Medical Expenses reimbursed shall be limited to those allowed under Code Section 223. "Incurred" means when the Participant is provided with the medical care that gives rise to the Qualifying Medical Expense and not when the Participant formally billed or charged for, or pays for, the medical care.

1.17 "Spouse" means a spouse as determined under federal tax law.

ARTICLE II
PARTICIPATION

2.1 Eligibility

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

2.2 Effective Date of Participation

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

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

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

2.3 Termination of Participation

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

ARTICLE III
BENEFITS

3.1 Establishment of Plan

(a) This Health Reimbursement Arrangement is intended to qualify as a Health Reimbursement Arrangement under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder.

(b) Participants in this Health Reimbursement Arrangement may submit claims for the reimbursement of Qualifying Medical Expenses as defined under the Plan and the Adoption Agreement. Unless otherwise elected in the Adoption Agreement, this Plan shall reimburse any expenses only after amounts in all other Plans that could reimburse the expense have been exhausted.

(c) The Employer shall make available to each Participant an Employer Contribution as elected in the Adoption Agreement, for the reimbursement of Qualifying Medical Expenses. No salary reductions may be made to this Health Reimbursement Arrangement.

(d) This Plan shall not be coordinated or otherwise connected to the Employer's cafeteria plan (as defined in Code Section 125), except as permitted by the Code and the Treasury regulations thereunder, to the extent necessary to maintain this Plan as a Health Reimbursement Arrangement.

(e) If the Employer maintains Health Savings Accounts for Participants, this Arrangement shall be operated in accordance with the restrictions under Code Section 223.

3.2 Nondiscrimination Requirements

(a) It is the intent of this Health Reimbursement Arrangement not to discriminate in violation of the Code and the Treasury regulations thereunder.

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

3.3 Health Reimbursement Arrangement Claims

(a) The Administrator shall direct the reimbursement to each eligible Participant for all Qualifying Medical Expenses. All Qualifying Medical Expenses eligible for reimbursement pursuant to Section 3.1(b) shall be reimbursed during the Coverage Period, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Qualifying Medical Expenses were incurred during a Coverage Period. Claims must include receipts or documentation that the expense being incurred is eligible for reimbursement, in order to claim reimbursement. Expenses may be reimbursed in subsequent Coverage Period, subject to the provisions of Number 21 on the Adoption Agreement and Section 3.3(c) below. However, a Participant may not submit claims incurred prior to beginning participation in the Plan and/or the Effective Date of the Plan, whichever is earlier.

(b) Notwithstanding the foregoing, if elected in the Adoption Agreement, Qualifying Medical Expenses shall not be reimbursable under this Plan if eligible for reimbursement and claimed under the Employer's Health Flexible Spending Account or Health Savings Account, if applicable.

(c) Claims for the reimbursement of Qualifying Medical Expenses incurred in any Coverage Period shall be paid as soon after a claim has been filed as is administratively practicable. However, if a Participant fails to submit a claim within the period elected at Question 21 on the Adoption Agreement immediately following the end of the Coverage Period or calendar year, as selected, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

(d) Reimbursement payments under this Plan shall be made directly to the Participant.

(e) If the maximum amount available for reimbursement for a Coverage Period is not utilized in its entirety, such remainder shall be carried forward to another Coverage Period or forfeited, as elected in the Adoption Agreement.

3.4 Debit and Credit Cards

(a) Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Qualifying Medical Expenses, as set forth in this Section.

(b) Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(c) Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Coverage Period the Participant remains a Participant in the Health Reimbursement Arrangement. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant withdraws from the Health Reimbursement Arrangement.

(d) The maximum dollar amount of coverage available shall be the maximum amount for the Coverage Period as set forth on the Adoption Agreement.

(e) The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.

(f) The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs obtained with a prescription;

(3) Purchase of medical items such as eyeglasses, syringes, insulin, crutches, etc.

(g) Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43, Notice 2006-69, and any subsequent guidance. All charges shall be conditional pending confirmation and substantiation.

(h) If such purchase is later determined by the Administrator to not to qualify as a Qualifying Medical Expense, the Administrator, in its discretion, shall use the one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid.

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

3.5 Opt Out

A Participant may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, elect to permanently opt out of reimbursement under this Plan. This election must be made in writing and shall be allowed at least annually or more frequently if elected on the Adoption Agreement.

ARTICLE IV
PROVISIONS

4.1 Claim for Benefits

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

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

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

(a) The specific reason or reasons for the denial.

(b) Reference to the specific Plan provisions on which the denial was based.

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(d) A description of the Plan's review procedures and the time limits applicable to such procedures.

(e) A statement that the claimant is entitled to receive, upon request and free of charge reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

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

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

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

(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.

4.2 Named Fiduciary

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

4.3 General Fiduciary Responsibilities

The Administrator and any other fiduciary shall discharge its duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and:

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent.

4.4 Nonassignability of Rights

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

ARTICLE V
ADMINISTRATION

5.1 Plan Administration

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

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;

(d) To limit benefits for certain highly compensated individuals if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(f) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

(g) To establish and communicate procedures to determine whether a medical child support order is qualified.

(h) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan; and

(i) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

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

5.2 Examination of Records

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

5.3 Indemnification of Administrator

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

5.4 Coordination of Benefits

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

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

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

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

(a) Group or group-type plans, including franchise or blanket benefit plans.

(b) Group practice and other group prepayment plans.

(c) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(d) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(e) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable, at least part of the charge must be covered under this Plan.

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

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

(a) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(b) Plans with a coordination provision will pay their benefits up to the Allowable Charge.

(c) The benefits of the plan which covers the person directly (that is, as an Employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

(d) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(e) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those benefits of a benefit plan which covers that person as a laid-off or retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(f) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(g) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(1) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(2) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(h) When a child's parents are divorced or legally separated, these rules will apply:

(1) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(2) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(3) This rule will be in place of items (1) and (2) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(4) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(5) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(i) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(j) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS.

(k) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(l) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

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

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

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

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

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

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

5.5 Right of Subrogation and Refund

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

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

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

The Participant and his or her Dependents:

(a) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(b) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Participant and his or her Dependents agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%,

first dollar priority over any and all Recoveries and funds paid by a Third Party to a Participant and his or her Dependents relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Participant and his or her Dependents may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Participant and his or her Dependents' Third Party Claims.

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

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

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

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

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

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

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

Recovery from another plan under which the Participant and his or her Dependents is covered. This right of Refund also applies when a Participant and his or her Dependents recovers under an uninsured or

underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

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

ARTICLE VI
AMENDMENT OR TERMINATION OF PLAN

6.1 Amendment

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

6.2 Termination

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

ARTICLE VII
MISCELLANEOUS

7.1 Plan Interpretation

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

7.2 Gender and Number

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

7.3 Written Document

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

7.4 Exclusive Benefit

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

7.5 Participant's Rights

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or

Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

7.6 Action by the Employer

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

7.7 No Guarantee of Tax Consequences

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

7.8 Indemnification of Employer by Participants

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

7.9 Funding

Unless otherwise required by law, amounts made available by the Employer need not be placed in trust, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

7.10 Governing Law

This Plan shall be construed and enforced according to the Code, and the laws of the state or commonwealth in which the Employer's principal office is located (unless otherwise designated in the Adoption Agreement), other than its laws respecting choice of law.

7.11 Severability

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

7.12 Headings

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

7.13 Continuation of Coverage

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

7.14 Family and Medical Leave Act

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

7.15 Health Insurance Portability and Accountability Act

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

7.16 Uniformed Services Employment and Reemployment Rights Act

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

7.17 HIPAA Privacy Standards

(a) If this Plan is subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) The Plan shall not disclose Protected Health Information to any member of Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(c) Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative

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

(d) The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

7.18 HIPAA Electronic Security Standards

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

(a) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 7.17.

(d) The Plan shall not disclose Protected Health Information to any member of Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall

mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(e) Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care.

(f) The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(g) The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

7.19 Mental Health Parity and Addiction Equity Act

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

7.20 Genetic Information Nondiscrimination Act (GINA)

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

7.21 Women's Health and Cancer Rights Act

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

7.22 Newborns' and Mothers' Health Protection Act

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

HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

03/15/2017

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HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

We are pleased to establish this Health Reimbursement Arrangement to provide you with additional health coverage benefits. The benefits available under this Plan are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. 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.

I
ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan?

You will be eligible to join the Plan once you become covered under our group medical plan.

2. When is My Entry Date?

You can join the Plan on the same day that you enter our group medical plan.

3. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

Employees who are not participants in our group medical plan.

II
BENEFITS

1. What Benefits Are Available?

The plan allows you to be reimbursed for certain out-of-pocket medical expenses which are incurred by you and your dependents. These expenses include medical deductible expenses under the group medical plan.

Individual-
The participant must meet the initial $1,000 of medical deductible expenses before the HRA will reimburse eligible expenses up to a total benefit of $1,000.

Family-
One family member must meet the initial $1,000 before the HRA will reimburse eligible medical deductible expenses up to a max per person benefit of $1,000. The remaining family will need to meet the additional $1,000 (Family max $2,000) of eligible medical deductible and the HRA will reimburse up to the family max benefit of $2,000.

Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including our health flexible spending account if participating.

You may submit expenses for yourself, your spouse, or your children including step children and foster children. You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

2. When Must Expenses Be Incurred?

You may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each October 1 and ends September 30. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

3. When Will I Receive Payments From the Plan?

During the course of the Coverage Period, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 90 days after the end of the Coverage Period. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

4. What Happens If I Terminate Employment?

If your employment is terminated during the Coverage Period for any reason, your participation in the Plan will cease and any unused amounts are forfeited, unless you elect to continue your coverage pursuant to Article V. If you do not elect to continue coverage you must submit claims for services incurred prior to your termination date no later than 90 days after the end of the Coverage Period.

Retirees maybe subject to continuation of benefits please review the attached Addendum for eligibility rules.

5. Can I Opt Out of the Plan?

Yes, you have the ability to opt out the Plan and receive no further reimbursement prior to the start of each new Coverage Period. You must notify your Employer in writing if you wish to opt out of coverage.

6. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Coverage Period upon your return.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

7. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

8. Newborns' and Mothers' Health Protection Act

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 newborn child 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 or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

9. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

III
General Information About Our Plan

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

1. General Plan Information

Johnson County Health Reimbursement Arrangement is the name of the Plan.

Your Employer has assigned Plan Number 510 to your Plan.

The provisions of your Plan become effective on October 1, 2022.

2. Employer Information

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

Johnson County
2 N Main Street Room 215
Cleburne, TX 76033
75-6001030

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Administrator.

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Johnson County
2 N Main Street Room 215
Cleburne, TX 76033
(817) 556-6350

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. Third Party Claims Administrator Information

The name, address and business telephone number of the Third Party Claims Administrator are:

Alerus Retirement and Benefits
P.O. Box 64535
St. Paul, MN 55164-0535

Reimbursement Request for expenses should be submitted to the Alerus via the website, mobile app, fax or by mail to the address listed above.

The Third Party Claims Administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

5. Service of Legal Process

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

6. Type of Administration

The Plan is a health reimbursement arrangement
and the claims administration is provided through a Third-Party Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

IV
ADDITIONAL PLAN INFORMATION

1. How to Submit a Claim

When you have a claim to submit for payment, you must:

(a) Obtain a claim form from the Plan Administrator.

(b) Complete the Employee portion of the form.

(c) Attach copies of all bills from the service provider for which you are requesting reimbursement.

A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

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

(a) The specific reason or reasons for the denial.

(b) Reference to the specific Plan provisions on which the denial was based.

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(d) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(e) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will 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;

(d) 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.

V
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this Arrangement will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Arrangement would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA. The Arrangement itself can provide group health benefits and may also be used to provide health benefits through insurance. Whenever "Arrangement" is used in this section, it means any of the health benefits under this Plan.

What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Arrangement (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage

through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under the Arrangement by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Arrangement as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Arrangement due to his or her performance of services for the employer sponsoring the Arrangement. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Arrangement provided that the participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(d) A covered Employee's enrollment in any part of the Medicare program.

(e) A Dependent child's ceasing to satisfy the Arrangement's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Arrangement).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Arrangement under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Arrangement occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Arrangement that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Arrangement provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Arrangement during the FMLA leave.

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments**: If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility**: You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.

- **Service Areas**: If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing**: In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the Procedure for Obtaining COBRA Continuation Coverage?

The Arrangement has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the
election period.

What is the Election Period and How Long Must It Last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Arrangement. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months

immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Arrangement will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment or reduction of hours of employment,

(b) death of the employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the employee to any part of Medicare,

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Johnson County
2 N Main Street Room 215
Cleburne, TX 76033

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost (if under your coverage the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. "on the date of the Qualifying Event"). If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA Coverage Available If a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When May a Qualified Beneficiary's COBRA Continuation Coverage Be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment is not made to the Arrangement with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(e) The date, after the date of the election that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(f) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Arrangement can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Arrangement terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Arrangement solely because of the individual's relationship to a Qualified Beneficiary, if the Arrangement's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Arrangement is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under What Circumstances Can the Maximum Coverage Period Be Expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. The Plan Administrator must be

notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

Does the Arrangement Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Arrangement, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of any costs. The Arrangement will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Arrangement Allow Payment for COBRA Continuation Coverage to Be Made in Monthly Installments?

Yes. The health coverage is also permitted to allow for payment at other intervals.

What is Timely Payment for Payment for COBRA Continuation Coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Arrangement by a later date is also considered Timely Payment if either under the terms of the Arrangement, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Arrangement does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to those providing coverage.

If Timely Payment is made to the Arrangement in an amount that is not significantly less than the amount the Arrangement requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Arrangement's requirement for the amount to be paid, unless the Arrangement notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary Be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Arrangement will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Arrangement. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.