Summary Plan Description

For Walla Walla University
Health Reimbursement Arrangement
Effective January 1, 2015

HEALTH REIMBURSEMENT ARRANGEMENT

Summary Plan Description

INTRODUCTION

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

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

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

PART A
GENERAL INFORMATION ABOUT OUR PLAN/ADOPTION AGREEMENT

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

1. General Plan Information Walla Walla University Health Reimbursement Arrangement is the name of the Plan.

2. The provisions of your Plan became effective on January 1, 2015, which is called the Effective Date of the Plan.

3. Your Plan is a Perpetual HRA with a plan start date that begins on 1/1/2015 with no plan end date.

4. Your Employer has assigned Plan Number 535 to your Plan.
5. Employer Information

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

Walla Walla University
204 S. College Ave.
College Place, WA 99324
91-0617727
509-527-2302

6. The Plan shall be governed under the laws of the State of WA.

7. Plan Administrator Information

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

Same as employer’s above

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

8. Service of Legal Process

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

9. Type of Administration

The type of Administration is Employer Administration.

10. Eligibility Requirements.

This HRA is integrated with underlying, ACA-compliant group coverage, and is available to those enrolled in the ACA-compliant plan, as well as Employees who may obtain coverage under a Spouse’s ACA-compliant group coverage. Notwithstanding the above, all Employees are considered eligible to participate in this Plan except:

- Self-employed person(s), within the meaning of Code Section 401(c), including independent contractors, a greater than 2% shareholder in a Subchapter S corporation, a partner in a partnership, or any owner or member of a limited liability company that is treated like a partnership for tax purposes;
- A relative, within the meaning of IRC Section 318, of one of the above self-employed person(s);
- Employees not eligible and electing Employer’s group medical plan AND:
  - Part-time Employees expected to work at less than _______ hours per week.
  - Commissioned Employees
  - Union Employees (which shall include any Employee of the Employer who is included in a unit of employees covered by an agreement which the Secretary of Labor finds to be a collective bargaining agreement between employee representatives and one or more employers), unless the collective bargaining agreement requires the employee to be included within the Plan.
  - Temporary or seasonal Employees (working for the Employer less than 6 months of the year)
  - Leased Employees, as well as any independent contractor, or other "statutory employee" who is not treated as a common law employee of the Employer for payroll purposes, regardless of any other court or administrative agency determination.
- Nonresident Aliens
For purposes of determining continued eligibility under the Plan, Retirees shall be eligible to continue participation in the Plan.

“Retirees” shall only be considered as those employees who have satisfied the Employer’s terms and conditions for retirement. For our Plan, “Retirement” shall be considered as being only those employees who:

- Have reached years of age
- A combination of years of service and age, to equal
- Other: Qualify for retirement through the Adventist Retirement Plan

Terminated employees shall:

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

11. **Plan Entry Date.** The Entry Date for eligible Employees shall be:

- 0 days after date of hire.

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

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

- Medical Expenses
- Dental Expenses
- Vision Expenses

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

**Eligible Medical Expenses.** The following categories of expenses qualify for reimbursement under the Plan:

- **Comprehensive.** All medical expenses not otherwise covered by insurance (e.g., co-pays, deductibles, etc.), except as otherwise described as follows:
  
  - **Bridge.** Only those expenses that are covered under insurance, but subject to a deductible. Coverage will be provided for out-of-pocket costs of up to of the total deductible limit.
  
  - **Benefits.** Benefits under this Plan shall be paid BEFORE the employee is responsible for his portion of the deductible limit.
  
  - Co-insurance charges will be included as otherwise eligible expenses.

- **Limited.** Only those expenses that are not otherwise covered by insurance (e.g., co-pays, deductibles, etc.), as further selected as follows:
  
  - Dental Expenses;
  
  - Vision Expenses;
  
  - Prescription Drugs;
  
  - Other:
• **Premium Only.** Only the employee’s applicable premium of the following employer-provided insurance coverages:
  • Health Insurance Premiums;
  • Dental Insurance Premiums;
  • Disability Insurance Premiums;
  • Long-term Care Insurance Premiums;
  • Other:

13. **Annual Limit.**

Health Reimbursement Arrangement is subject to an annual limit of: see chart below.

This Plan is not interest-bearing.

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<th>Description</th>
<th>Annual Limit</th>
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<td>Family</td>
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<td>Individual</td>
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• Newly-eligible participants may have access to the Annual Limit at the time of plan entry.

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

14. **Access to Benefits.** Other than for Retiree/COBRA continuees, the employer shall make all contributions for this Plan. The employer shall make access to benefits under the plan in the following manner:

• On an annual basis at the beginning of the Plan Year.
• On a quarterly basis at the beginning of each quarter within the Plan Year.
• On a quarterly basis at the beginning of each month within the Plan Year.
• On a pro rata basis, coordinating with employee pay dates, within the Plan Year

15. **Order of Benefit Payments.** If the Employer sponsors a Section 125 Flexible Spending Arrangement, in addition to this Plan:

• Eligible Medical Expenses must be paid under the Section 125 Plan before this Plan;
• Eligible Medical Expenses must be paid under the Section 125 Plan after this Plan;
• Applicable health insurance premiums are paid under this Plan before being paid under the Section 125 Plan.

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

16. **Carry over amounts.** 100 Percentage of the Account Balance can be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution by the employer. With Account Balance not to exceed $100. (None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred.)

17. **Mid-Year Claims Deadline Run-Out Period (Applies to Mid-Year Term or Cancel)**

• No Mid-Year Claims Deadline
• No End-of-Plan Claims Deadline

18. **Claims.** Outstanding claims may be considered for the next plan year.
19. COBRA Continuation: Qualified employees ☑ may not be required to elect COBRA continuation for Employer sponsored medical insurance before being eligible to elect COBRA continuation for the Heath Reimbursement Arrangement, to the extent the Employer is subject to COBRA as set forth in the relevant Code, Employees Retirement Income Security Act of 1974 (“ERISA”), and/or Public Health Safety Act (“PHSA”) statutory provisions and the applicable regulations promulgated thereunder.

20. Name and Address of Plan Continuation Coverage Administrator:

Not Applicable

21. Rights Upon Termination. If terminated Employees waive Continuation Coverage rights, the Spend-Down Option ☑ is offered.

22. Affiliated Employers participating in the Plan:

Not Applicable

23. The HRA is funded with: ☑ General Assets.

Authorized Signatures:

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<th>Employer</th>
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Corporate Resolution

For Walla Walla University
Health Reimbursement Arrangement
Effective January 1, 2015

Certificate of Corporate Resolution

The undersigned Secretary or Principal of Walla Walla University (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer on January 1, 2015 and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of Health Reimbursement Arrangement effective January 1, 2015, presented to this meeting is hereby approved and adopted and that the duly authorized agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

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

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

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

________________________________________________
Secretary/Principal

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

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

I-2. When did the Plan take effect?

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

I-3. Who can participate in the Plan?

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

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

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

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

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

I-6. How do I become a Participant?

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

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

I-7. How do I receive my benefits under the Plan?
When you incur an eligible medical or dental expense, you must submit a claim reimbursement request to the Plan's Administrator within the time frames specified under Part C, Section 2 set forth below. If the Plan Administrator determines that your claim is valid, you will be reimbursed for your eligible expenses as soon as is administratively feasible after it has been submitted. You may submit a claim for any eligible medical or dental expense arising during the Plan Year at any time during the period that begins when the expense is incurred. Remember, though, you can't be reimbursed for any total expenses above the annual amount of benefit the Company has provided plus any unused carryover amounts from the previous calendar year. If your claim arises while you have COBRA continuation coverage (see Answer I-17), all required premiums for the coverage (subject to a 30-day grace period for late payment of premiums) also must have been received by the Company prior to the request for reimbursement of otherwise allowable expenses.

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

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

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

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

I-9. What is an “eligible expense?”

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

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

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

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

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

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

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

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

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

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

Generally yes. Your normal participation will cease at the end of the last day before your employment with the Company terminates. However, you may still receive reimbursement of any eligible expenses, as otherwise provided for under the Plan, as long as such reimbursement requests are made prior to the expiration of the run-out period described in Part A, General Information About Our Plan in the Summary Plan Description. In addition, you and your family will also have the opportunity to continue to be covered under the Plan under the terms of the Continuation Coverage provisions described in Answer I-17, below. Under all circumstances, coverage ends upon the earlier of your death or the date the Plan terminates.
1-14. Will my coverage end if I go on a family or medical leave under the FMLA?

Subject to certain conditions, the Family and Medical Leave Act ("FMLA") entitles you to take unpaid leaves of absence totaling 12 weeks per year for specific personal or family health and child care needs. Your coverage under the Plan will continue while you are on an FMLA leave as long as you opt to continue your coverage under the Plan and continue to make any applicable premium contributions that would otherwise be paid by your employer. Upon your return you will be permitted to re-enter the Plan on the same basis that you were participating in prior to taking FMLA leave. However, you will lose coverage when you fail to return to work at the end of the leave or give earlier notice that you will not be returning to active employment.

1-15. Does my coverage continue while I am absent on duty in the uniformed services?

The Plan will continue to reimburse you or your family for eligible medical expenses (except for any illness or injury suffered by you in connection with duty in the uniformed services) for the first 30 days of your absence. However, coverage after that period will be suspended while you are on approved military service leave, unless you opt to continue coverage under the Plan in accordance with the procedures set forth in Answer 1-17. No re-entry requirements will be imposed if you return to active employment within 30 days of taking leave of employment for duty in the uniformed services.

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

1-16 Which Plan pays first if I am already enrolled in a Flexible Spending Account?

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

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

1-17. What is “Continuation Coverage,” and how does it work?

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

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours below what is required for participation under this Plan.
- your death.
- divorce or legal separation from your spouse.
- your becoming entitled to receive Medicare benefits.
- when a dependent of yours ceases to be a dependent.
It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs. The notice of these rights that you will receive will explain all the rest of the terms and conditions of the continued coverage.

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

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

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

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

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

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

PART C
ADDITIONAL PLAN INFORMATION
1. Plan Accounting

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

2. Claims Instructions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
b) The reasons for the denial;
c) Reference to the specific provisions of the Plan on which the denial was based;
d) A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
e) A description of the Plan’s internal review procedures and time limits applicable to such procedures, available external review procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal;
f) A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
g) A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol or other similar criteria will be provided, free of charge, upon request;
h) The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

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

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

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

5. Non-Discrimination Requirements

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

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

7. No Employment Rights Conferred

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

8. HIPAA Privacy

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

Protected Health Information or “PHI” is health information that is created or received by the Plan. PHI relates to your physical or mental health or condition, the provision of health care to you, or the payment for the provision of health care to you. Typically, the information identifies you, your diagnosis, and treatment or supplies used in the course of your treatment. Electronic Protected Health Information (also known as “ePHI”) is PHI stored in any electronic media, including any memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card or the transmission or exchange of information through usage of the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media, but does not include facsimile or voice transmissions and is limited to the information created, maintained, transmitted or received by or on behalf of the Plan.

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

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

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

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

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

PART D
SUMMARY

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

If you have any questions, please contact the Administrator.
Attachment A

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

INTRODUCTION

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

CONTINUATION COVERAGE FOR EMPLOYEE (COBRA)

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

1.1 QUALIFYING EVENTS

1. Termination of employment (for reasons other than gross misconduct.)
2. Involuntary termination of employee.
3. Reduction in hours of employment.

CONTINUATION COVERAGE FOR SPOUSE OF EMPLOYEE

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

1.2 QUALIFYING EVENTS

1. A termination of your spouse’s employment (for reasons other than gross misconduct).
2. Reduction in your spouse’s hours of employment.
3. The death of your spouse.
4. Divorce or legal separation from your spouse.
5. Your spouse becomes entitled to Medicare.

CONTINUATION COVERAGE FOR DEPENDENT OF EMPLOYEE

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

1.3 QUALIFYING EVENTS
1. The termination of an employee parent’s employment (for reasons other than gross misconduct).

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

3. The death of your employee parent.

4. Parent’s divorce or legal separation.

5. Employee parent becoming entitled to Medicare.

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

1.4 **NOTIFICATION AND PREMIUMS**

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

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

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

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

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

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

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

1.5 **TERMINATION OF RIGHTS**

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

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

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

3. You are or become covered under another group health plan other than the plan of the employer providing continuation as long as no exclusionary period will be imposed on a preexisting condition.
4. You are or become entitled to Medicare. However, if it is determined that Medicare is to be the secondary payor, your continuation coverage under your current health plan(s) is primary until Medicare becomes primary, or continuation coverage is otherwise terminated, whichever is earlier.

1.6 ADDITIONAL INFORMATION

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

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

1.7.1 QUALIFIED BENEFICIARIES

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

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

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

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

Uses and Disclosures of Health Information.

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

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

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

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

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

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

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

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.
**Right to Request Restrictions.** You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

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

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

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

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

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