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**HRA105**  
**HEALTH REIMBURSEMENT ARRANGEMENT**  
*PLAN DOCUMENT*

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*AS ADOPTED BY*  
*WHITE RIVER VALLEY SUPERVISORY UNION*  
*EFFECTIVE 12/31/2018*

# TABLE OF CONTENTS

|   |          |
|---|----------|
| <b><u>ARTICLE I: DEFINITIONS</u></b> .....                    | <b>2</b> |
| 1.01 <u>Affiliated Employer</u> .....                         | 2        |
| 1.02 <u>Anniversary Date</u> .....                            | 2        |
| 1.03 <u>Benefits</u> .....                                    | 2        |
| 1.04 <u>Board of Directors</u> .....                          | 2        |
| 1.05 <u>CAP</u> .....   | 2        |
| 1.06 <u>Carry-Over Amounts</u> .....                          | 2        |
| 1.07 <u>Claims Submission Run-Out Period</u> .....            | 2        |
| 1.08 <u>Run-Out Period</u> .....                              | 2        |
| 1.09 <u>Code</u> .....  | 2        |
| 1.10 <u>Contribution Period</u> .....                         | 3        |
| 1.11 <u>Coverage Period</u> .....                             | 3        |
| 1.12 <u>Dependent</u> .....                                   | 3        |
| 1.13 <u>Effective Date</u> .....                              | 3        |
| 1.14 <u>Eligible Medical Expenses</u> .....                   | 3        |
| 1.15 <u>Employee</u> .....                                    | 3        |
| 1.16 <u>Employer</u> .....                                    | 3        |
| 1.17 <u>Employer Contributions</u> .....                      | 3        |
| 1.18 <u>ERISA</u> .....                                       | 3        |
| 1.19 <u>FMLA</u> .....  | 3        |
| 1.20 <u>FMLA Leave</u> .....                                  | 3        |
| 1.21 <u>Gap</u> .....   | 3        |
| 1.22 <u>Group Health Plan</u> .....                           | 3        |
| 1.23 <u>High Deductible Health Coverage (“HDHC”)</u> .....    | 3        |
| 1.24 <u>Health Reimbursement Account (“HRA”)</u> .....        | 4        |
| 1.25 <u>Highly Compensated Individual</u> .....               | 4        |
| 1.26 <u>Linked HRA</u> .....                                  | 4        |
| 1.27 <u>Participant</u> .....                                 | 4        |
| 1.28 <u>Plan</u> .....  | 4        |
| 1.29 <u>Plan Administrator or Committee</u> .....             | 4        |
| 1.30 <u>Plan Service Provider</u> .....                       | 4        |
| 1.31 <u>Plan Year</u> .....                                   | 4        |
| 1.32 <u>Spend-Down Option</u> .....                           | 4        |
| 1.33 <u>Spouse</u> .....                                      | 4        |
| 1.34 <u>Summary Plan Description</u> .....                    | 4        |
| 1.35 <u>USERRA</u> .....                                      | 4        |
| 1.36 <u>USERRA Leave</u> .....                                | 4        |
| <b><u>ARTICLE II: ELIGIBILITY AND PARTICIPATION</u></b> ..... | <b>4</b> |
| 2.01 <u>Eligibility to Participate</u> .....                  | 4        |
| 2.02 <u>Termination of Participation</u> .....                | 5        |
| 2.03 <u>Leave of Absence</u> .....                            | 5        |
| 2.04 <u>Qualified Medical Child Support Orders</u> .....      | 5        |
| <b><u>ARTICLE III: BENEFITS UNDER THE PLAN</u></b> .....      | <b>6</b> |
| 3.01 <u>Annual Benefits Provided by the Plan</u> .....        | 6        |
| 3.02 <u>Employer Contributions</u> .....                      | 6        |
| 3.03 <u>Direct Benefit Payments</u> .....                     | 6        |
| 3.04 <u>Method of Funding Coverage</u> .....                  | 6        |
| <b><u>ARTICLE IV: UNUSED REIMBURSEMENT FUNDS</u></b> .....    | <b>6</b> |
| 4.01 <u>Carry-Over Funds</u> .....                            | 6        |
| <b><u>ARTICLE V: PAYMENT OF BENEFITS</u></b> .....            | <b>6</b> |
| 5.01 <u>Claim For Benefits</u> .....                          | 6        |

|  |   |           |
|--|---|-----------|
| 5.02   | <a href="#">Required Documentation</a>                                      | 6         |
| 5.03   | <a href="#">Limitation on Benefits</a>                                      | 7         |
| 5.04   | <a href="#">Reimbursement of Expenses</a>                                   | 7         |
| 5.05   | <a href="#">Coordination of Benefits</a>                                    | 7         |
| <b><u>ARTICLE VI: CONTINUATION COVERAGE UNDER COBRA AND USERRA</u></b> |   | <b>7</b>  |
| <b><u>ARTICLE VII: SPEND-DOWN OPTION</u></b>                           |   | <b>7</b>  |
| 7.01   | <a href="#">Purpose</a>   | 7         |
| 7.02   | <a href="#">Availability</a>  | 8         |
| 7.03   | <a href="#">Spend-Down Period</a>   | 8         |
| 7.04   | <a href="#">Spend-Down Run-Out Period</a>                                   | 8         |
| 7.05   | <a href="#">Qualifying Spend-Down Event</a>                                 | 8         |
| 7.06   | <a href="#">Eligible Spend-Down Expenses</a>                                | 8         |
| 7.07   | <a href="#">Current Plan Year's HRA</a>                                     | 8         |
| 7.08   | <a href="#">Spend-Down Election Period</a>                                  | 8         |
| 7.09   | <a href="#">Spend-Down Participant is Rehired or Regains Eligibility</a>    | 8         |
| <b><u>ARTICLE VIII: PLAN ADMINISTRATION</u></b>                        |   | <b>8</b>  |
| 8.01   | <a href="#">Allocation of Authority</a>                                     | 8         |
| 8.02   | <a href="#">Provision for Third-Party Plan Service Providers</a>            | 9         |
| 8.03   | <a href="#">Fiduciary Liability</a>   | 9         |
| 8.04   | <a href="#">Compensation of Plan Administrator</a>                          | 9         |
| 8.05   | <a href="#">Bonding</a>   | 9         |
| 8.06   | <a href="#">Payment of Administrative Expenses</a>                          | 9         |
| <b><u>ARTICLE IX: CLAIMS PROCEDURES</u></b>                            |   | <b>9</b>  |
| <b><u>ARTICLE X: AMENDMENT OR TERMINATION OF PLAN</u></b>              |   | <b>9</b>  |
| 10.01  | <a href="#">Permanency</a>  | 9         |
| 10.02  | <a href="#">Employer's Right to Amend</a>                                   | 10        |
| 10.03  | <a href="#">Employer's Right to Terminate</a>                               | 10        |
| 10.04  | <a href="#">Determination of Effective Date of Amendment or Termination</a> | 10        |
| <b><u>ARTICLE XI: HIPAA PRIVACY AND SECURITY</u></b>                   |   | <b>10</b> |
| 11.01  | <a href="#">Scope and Purpose</a>   | 10        |
| 11.02  | <a href="#">Definitions</a>   | 10        |
| 11.03  | <a href="#">Responsible Employees</a>                                       | 12        |
| 11.04  | <a href="#">Permitted Uses and Disclosures</a>                              | 13        |
| 11.05  | <a href="#">Certification Requirement</a>                                   | 13        |
| 11.06  | <a href="#">Mitigation</a>  | 14        |
| 11.07  | <a href="#">Breach Notification</a>   | 14        |
| <b><u>ARTICLE XII: GENERAL PROVISIONS</u></b>                          |   | <b>14</b> |
| 12.01  | <a href="#">Not an Employment Contract</a>                                  | 14        |
| 12.02  | <a href="#">Applicable Laws</a>   | 14        |
| 12.03  | <a href="#">Post-Mortem Payments</a>  | 15        |
| 12.04  | <a href="#">Non-alienation of Benefits</a>                                  | 15        |
| 12.05  | <a href="#">Mental or Physical Incompetency</a>                             | 15        |
| 12.06  | <a href="#">Inability to Locate Payee</a>                                   | 15        |
| 12.07  | <a href="#">Requirement for Proper Forms</a>                                | 15        |
| 12.08  | <a href="#">Source of Payments</a>  | 15        |
| 12.09  | <a href="#">Multiple Functions</a>  | 15        |
| 12.10  | <a href="#">Tax Effects</a>   | 15        |
| 12.11  | <a href="#">Gender and Number</a>   | 15        |
| 12.12  | <a href="#">Headings</a>  | 15        |
| 12.13  | <a href="#">Incorporation by Reference</a>                                  | 16        |
| 12.14  | <a href="#">Severability</a>  | 16        |
| 12.15  | <a href="#">Effect of Mistake</a>   | 16        |



# White River Valley Supervisory Union Health Reimbursement Arrangement PLAN DOCUMENT

White River Valley Supervisory Union ("Employer") has established this Health Reimbursement Arrangement (the "Plan") with one or more Health Reimbursement Accounts (HRAs) for its Employee for purposes of reimbursing eligible Employees of the Employer for the cost of certain Eligible Medical Expenses incurred by them, their Spouses and eligible Dependents. It is intended that the Plan meet the requirements for qualification under Internal Revenue Code § 106, and that benefits paid employees hereunder be excludable from their gross incomes by virtue of Internal Revenue Code § 105(b), as augmented by the Safe Harbor provisions of Rev. Rul. 2002-41 (June 26, 2002) and IRS Notice 2002-45 (June 26, 2002).

## Article I: Definitions

The following terms and definitions apply to this Plan.

### 1.01 **Affiliated Employer**

Any entity who, within the context of Code § 414(b), (c), or (m) of the Code, will be considered with the Employer as a single employer for purposes of Code § 105.

### 1.02 **Anniversary Date**

The first day of any Plan Year.

### 1.03 **Benefits**

Any amounts paid to a Plan Participant (or on behalf of the Participant) under the terms and conditions set forth herein as reimbursement for Eligible Medical Expenses incurred during the Participant's Coverage Period by a Participant, his Spouse, and/or his Dependents.

### 1.04 **Board of Directors**

The Board of Directors of the Employer or other governing body. The Board of Directors, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

### 1.05 **CAP**

Maximum amount of claims that can be paid during a specified length of time from a combination of Employer's Contributions and Employee Carry-Over Funds.

### 1.06 **Carry-Over Amounts**

Unused amounts under an HRA that are "carried over" after the Run-Out Period at the end of the Plan Year according to the parameters set forth in the Summary Plan Description.

### 1.07 **Claims Submission Run-Out Period**

Period of time beginning after a Participant's employment is terminated during which the Participant can submit claims for expenses incurred before date of termination.

### 1.08 **Run-Out Period**

Period of time beginning at end of Plan Year during which the Participant can submit claims for payment of Qualified Expenses incurred during that Plan Year.

### 1.09 **Code**

The Internal Revenue Code of 1986, as amended.

### 1.10 **Contribution Period**

The Period during which the Employer will contribute to the HRA

### 1.11 **Coverage Period**

Plan Year or portion thereof that the Employee participated in an HRA.

### 1.12 **Dependent**

Any individual who satisfies the conditions set forth in the Summary Plan Description.

### **1.13 Effective Date**

The effective date of the Plan as set forth in the Summary Plan Description.

### **1.14 Eligible Medical Expenses**

Those expenses incurred by the Participant, or the Participant's Spouse or Dependents, that satisfy the conditions set forth in the Summary Plan Description. However, at no time will the Eligible Medical Expenses include COBRA premium payments.

### **1.15 Employee**

Any individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any individual classified by the Employer as a leased employee (including, but not limited to, those individuals defined in Code § 414(n)), or an individual classified by the Employer as a contract worker or independent contractor, temporary employee or casual employee, self-employed individual as defined in Code Section 401(c), whether or not any such persons are on the Employer's W-2 payroll or any individual who performs services for the Employer but who is paid by a temporary or other employment agency.

### **1.16 Employer**

The Employer specified in the Adoption Agreement and any Affiliate of the Employer that adopts the Plan with the consent of the Employer, provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party administrator, or amendment or termination of the plan) the term "Employer" shall mean only the Employer identified in the Adoption Agreement. Affiliates who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

### **1.17 Employer Contributions**

Contributions made by Employer under this Plan on behalf of the Participants.

### **1.18 ERISA**

The Employee Retirement Income Security Act of 1974, as amended from time to time.

### **1.19 FMLA**

The Family and Medical Leave Act of 1993, as amended from time to time.

### **1.20 FMLA Leave**

A leave of absence that the Employer is required to extend to an Employee under the provisions of the FMLA.

### **1.21 Gap**

The portion between the High Deductible Health Coverage (HDHC) and the HRA for which the Employee has responsibility.

### **1.22 Group Health Plan**

The group health plan(s) established by the Employer and identified in the Summary Plan Description.

### **1.23 High Deductible Health Coverage ("HDHC")**

Group Health Plan with High Deductible Health Coverage.

### **1.24 Health Reimbursement Account ("HRA")**

One or more Health Reimbursement Accounts that are established under this Health Reimbursement Arrangement. The parameters for each HRA can be found in the Summary Plan Description.

### **1.25 Highly Compensated Individual**

Any individual defined under Code § 105(h), as amended, as a "highly compensated individual" or a "highly compensated employee."

### **1.26 Linked HRA**

An HRA that is connected to another Group Health Plan (i.e., generally High Deductible Health Coverage or an "HDHC"). The Employee must be a Participant in the HDHC to participate in its associated (linked) HRA.

### **1.27 Participant**

Any employee who becomes covered by the Plan in accordance with Article II herein.

**1.28 Plan**

This self-insured Health Reimbursement Arrangement set forth herein and described in the Summary Plan Description.

**1.29 Plan Administrator or Committee**

The person(s) appointed by the Employer with authority and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

**1.30 Plan Service Provider**

Person or Person(s) designated by the Plan Administrator (with approval of the Employer) to perform certain claims processing (including the initial determination as to whether a claim is payable) and day-to-day administrative duties.

**1.31 Plan Year**

The period of coverage for this Plan as specified in the Summary Plan Description.

**1.32 Spend-Down Option**

Continuation coverage that may be offered by the Employer as an alternative to COBRA continuation coverage in accordance with the parameters set forth in the Summary Plan Description.

**1.33 Spouse**

An individual who satisfies the definition of a Spouse as set forth in the Summary Plan Description.

**1.34 Summary Plan Description**

This Plan's Summary Plan Description (with all appendices) adopted by the Employer and attached to this Plan Document as Attachment 1, amended from time to time. The Summary Plan Description and all appendices are incorporated hereto by reference.

**1.35 USERRA**

The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

**1.36 USERRA Leave**

A leave of absence that the Employer is required to extend to an Employee under the provisions of the USERRA.

## **Article II: Eligibility and Participation**

**2.01 Eligibility to Participate**

Each Employee who satisfies the eligibility conditions set forth in the Summary Plan Description shall be eligible to participate in this Plan.

**2.02 Termination of Participation**

Participation shall terminate as of the dates set forth in the Summary Plan Description.

**2.03 Leave of Absence**

Coverage during a leave of absence shall be governed by the rules set forth in the Summary Plan Description.

**2.04 Qualified Medical Child Support Orders**

(a) *Definitions.* For purposes of this Section 2.04, the following terms have the following meanings:

- (i) "Alternate recipient" means any child of a Participant who is recognized by a medical child support order as having a right to enrollment under the Plan with respect to the Participant.
- (ii) "Medical child support order" means any judgment, decree, or order (including approval of a settlement agreement) that
  - 1) provides for child support with respect to a child of a Participant under the Plan or provides for health benefit coverage for such child, made pursuant to a State domestic relations law (including a community property law), and relates to benefits under the Plan; or
  - 2) enforces a law relating to medical child support described in § 1908 of the Social Security Act with respect to the Plan, if such judgment, decree, or order is issued by a court of competent jurisdiction or through an

administrative process established under State law that has the force and effect of law under the applicable State law.

- (iii) “Qualified Medical Child Support Order” means a medical child support order that:
- 1) creates or recognizes the existence of an alternate recipient’s right to, or assigns to an alternate recipient the right to, receive group health benefits to which a Participant or beneficiary is eligible under the Plan;
  - 2) clearly specifies (a) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order; (b) a reasonable description of the type of coverage to be provided under the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined; (c) the period to which such order applies; and (d) each plan to which such order applies; and
  - 3) does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided thereunder, except to the extent necessary to meet the requirements of a law relating to medical child support described in § 1908 of the Social Security Act.
- (b) *Notice.* Upon the receipt of any medical child support order, the Plan Administrator shall promptly notify, in writing, the Participant and each alternate recipient named in the medical child support order (at the address included in the medical child support order) of the receipt of such order and the procedures for determining the qualified status of such medical child support order.
- (c) *Representative.* Any alternate recipient named in a medical child support order shall have the right to designate, by notice in writing to the Plan Administrator, a representative for the receipt of copies of notices that are sent to the alternate recipient with respect to such medical child support order.
- (d) *Determination by Plan Administrator.* Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order and shall notify, in writing, the Participant and each alternate recipient named in such order of such determination.
- (e) *Direct Payment of Benefits.* If the Plan Administrator shall determine that the medical child support order is a Qualified Medical Child Support Order, the Plan Administrator shall ensure that any payment of benefits pursuant to such order in reimbursement for expenses paid by an alternate recipient or an alternate recipient’s custodial parent or legal guardian shall be made directly to the alternate recipient or the alternate recipient’s custodial parent or legal guardian, as the case may be.
- (f) *National Medical Support Notice.* If the Plan Administrator receives a National Medical Support Notice under § 609(a)(5)(C) of ERISA, the notice shall constitute a Qualified Medical Child Support Order to the extent provided by, and shall be administered in accordance with, such section and guidance issued thereunder. If the Plan Administrator receives a medical child support order in which the name and mailing address of an official of a State or political subdivision is substituted for the mailing address of any alternate recipient, such official’s name and mailing address shall be deemed to be the name and mailing address of the alternate recipient as provided in the order, in accordance with § 609(a)(3) of ERISA, and if the order is determined to be a Qualified Medical Child Support Order, the Plan Administrator may pay benefits directly to such official in accordance with the order.

## **Article III: Benefits under the Plan**

### **3.01 Annual Benefits Provided by the Plan**

The Plan will reimburse Participants each Plan Year for Eligible Medical Expenses according to the parameters set forth in the Summary Plan Description.

### **3.02 Employer Contributions**

The manner and scope of Employer contributions made under the Plan shall be set forth in the Summary Plan Description. Except for the applicable premium during COBRA continuation coverage described in Article VI below and the nominal administrative fee required with the Spend-Down Option discussed in Article VII below, the Employee shall not contribute toward the cost of the Plan.

### **3.03 Direct Benefit Payments**

Employer, at its discretion, may pay any or all of the Eligible Medical Expenses directly to the health care provider in lieu of making reimbursement thereof. In such event, Employer shall be relieved of all further responsibility with respect to that particular medical expense.

### **3.04 Method of Funding Coverage**

The Employer shall fund coverage provided hereunder from its general assets. Notwithstanding the foregoing, the Employer may establish one or more trusts, including a voluntary employee beneficiary association (VEBA) within the meaning of Code § 501(c)(9), for the purpose of funding benefits to be provided under this Plan.

## **Article IV: Unused Reimbursement Funds**

### **4.01 Carry-Over Funds**

If it is determined that all or a portion of the annual employer contribution amount made available to a Participant for a Plan Year, as described in Article IV herein, exceeds the amount of Participant's Eligible Medical Expenses incurred during the Plan Year, the excess may be carried over to the extent set forth in the Summary Plan Description. Any amounts not permitted to be carried over in accordance with the Summary Plan Description shall be forfeited.

## **Article V: Payment of Benefits**

### **5.01 Claim For Benefits**

No benefit shall be paid hereunder unless a Participant has first submitted a written claim for benefits in accordance with the procedures set forth in 5.02 below and Article VIII herein. Upon receipt of a properly documented claim, the Employer shall reimburse the Participant in accordance within the terms of this Plan. Claims incurred during a Plan Year must be submitted no later than the end of the Run-Out Period set forth in the Summary Plan Description, except as set forth below.

If a Participant terminates employment, any claims for expenses incurred before the Participant's termination date must be submitted no later than the end of the Claims Submission Run-Out Period stated in the Summary Plan Description. If no Claims Submission Run-Out Period is defined, the claims must be submitted no later than the end of the Run-Out Period.

### **5.02 Required Documentation**

Any Participant applying for reimbursement under this Plan shall submit to Plan Service Provider all documentation required to be provided as set forth in the Summary Plan Description. A failure to comply with such requirements may, at the discretion of Plan Administrator, terminate any such participant's right to reimbursement.

### **5.03 Limitation on Benefits**

Reimbursement under this Plan shall be made by the Employer only in the event and to the extent that such reimbursement or payment is for an Eligible Medical Expense (as set forth in the Summary Plan Description) and has not been reimbursed from or is not otherwise reimbursable from any other source. In the event that there is another source (set forth in the Summary Plan Description) that will provide for reimbursement or payment in whole or in part, then the Employer shall be relieved of any liability hereunder to the extent of coverage under such other source.

### **5.04 Reimbursement of Expenses**

The Participant shall be reimbursed from the Participant's HRA, at such time and in such manner as set forth in the Summary Plan Description, for Eligible Medical Expenses for which the Participant makes written application and submits documentation in accordance with this Section 0 and 0. However, if the Employer so chooses, the participant may choose to make payment for eligible medical expense with an electronic payment card arrangement. The terms of the electronic payment card arrangement, if applicable, will be set forth in the SPD.

No reimbursement or payment will be made if the Participant's claim is for an amount less than the minimum payment amount as established in the Summary Plan Description. Notwithstanding the preceding sentence, claims for expenses incurred during a Plan Year that are submitted for reimbursement during the earlier of the end of a terminated employee's Claims Submission Run-Out Period or the last month of the Plan Year or within the Run-Out Period after the end of the Plan shall be paid regardless of whether they equal or exceed the minimum reimbursable amount, provided the balance in the Participant's HRA permits such reimbursement or payment. Payment less than the minimum payment amount will be made also when such payment exhausts the available funds for reimbursement.

### **5.05 Coordination of Benefits**

The Plan is intended to pay benefits solely for otherwise unreimbursed Eligible Medical Expenses. To the extent the otherwise Eligible Medical Expense is payable or reimbursable from another source, the other source shall pay or reimburse prior to payment or reimbursement from this Plan to the extent permitted under applicable law. Notwithstanding the preceding sentence, certain coverages (e.g., Medicare for Participants who are active employees and their Dependents, and TRICARE benefits as required by law) will pay benefits only after this Plan to the extent required by applicable law. In addition, the Plan

Administrator may require that a Health Flexible Spending Account or “Health FSA” (as defined in the proposed Code § 125 regulations) to reimburse the employee before the employee is reimbursed under this Plan with respect to Eligible Medical Expenses covered both by this Plan and the Health FSA. The ordering of the Health FSA and the HRA(s) will be set forth in the Summary Plan Description.

## **Article VI: Continuation Coverage under COBRA and USERRA**

To the extent the Employer is subject to the provisions of Code Section 4980B, COBRA continuation coverage shall be offered in accordance with the terms of the Summary Plan Description. In addition, continuation coverage shall be offered to individuals taking a military leave of absence in accordance with USERRA and the terms of the Summary Plan Description.

## **Article VII: Spend-Down Option**

### **7.01 Purpose**

The Spend-Down option allows employees who experience one of the Qualifying Spend-Down Events set forth in the Summary Plan Description to continue using all (or a portion thereof) of the accumulated HRA amount for reimbursement of Eligible Spend-Down Expenses incurred after the Qualifying Spend-Down Event (unless permitted in 0 below) until the available funds are exhausted or the Spend-Down Period (see 0) is exhausted. The remaining HRA amount that may be used during the Spend-Down Period shall be set forth in the Summary Plan Description. The Spend-Down Option shall not be offered in lieu of COBRA continuation coverage, but as an alternative option to COBRA continuation Coverage. An election of the Spend-Down Option shall be considered a waiver of the Participant’s right to elect COBRA continuation coverage (except in accordance with the Employee’s right to revoke a waiver of COBRA continuation coverage set forth in the Summary Plan Description) and an election of COBRA continuation coverage shall be considered a waiver of the Participant’s right to elect the Spend-Down Option, if available under the Plan.

### **7.02 Availability**

The Spend-Down option is offered only at the Plan Administrator’s discretion. The Summary Plan Description will indicate whether Spend-Down Option is available under the Plan.

### **7.03 Spend-Down Period**

The “Spend-Down Period” is the period of time during which Eligible Spend-Down Expenses can be incurred by the Participant and any Eligible Dependents. The Spend-Down Period begins at the time of the Qualifying Spend-Down Event and ends after the period of time set in the Summary Plan Description. The Spend-Down Period may vary depending on the Qualifying Spend-Down Event.

### **7.04 Spend-Down Run-Out Period**

“Spend-Down Run-Out Period” is the period of time (set forth in the Summary Plan Description) beginning after the end of the Spend-Down Period during which the Participant can submit claims for expenses incurred during the Spend-Down Period.

### **7.05 Qualifying Spend-Down Event**

To the extent the Spend-Down Option is offered under the Plan, the Qualifying Spend-Down Events which trigger eligibility for the Spend-Down Option shall be set forth in the Summary Plan Description.

### **7.06 Eligible Spend-Down Expenses**

Eligible Spend-Down Expenses under the Spend-Down option shall be defined in the Summary Plan Description.

### **7.07 Current Plan Year’s HRA**

All Employer contributions to the current Plan Year’s HRA(s) will cease on the date coverage ceases as a result of the Qualifying Spend-Down Event. The Participant can continue to submit claims under the HRA (in the same manner as before the Qualifying Spend-Down Event) for Eligible Medical Expenses incurred before the Qualifying Spend-Down Event. The claims can be submitted at any time before the end of the Claims Submission Run-Out Period (or, if a Claims submission Run-Out Period is not established, at the end of the Run-Out Period). At that time, any unused amounts (or a portion thereof) can be applied towards the Eligible Spend-Down Expenses incurred after the Spend-Down Period begins according to the procedures set in the Summary Plan Description.

### **7.08 Spend-Down Election Period**

The period during which the Employee must elect to participate in the Spend-Down Option is set forth in the Summary Plan Description. A participant can opt-out of the Spend-Down Option and future reimbursements from the Plan at any time by notifying the Plan Administrator.

#### **7.09 Spend-Down Participant is Rehired or Regains Eligibility**

If a Participant in the Spend-Down option is rehired or regains eligibility, the employee can elect HRAs in the same manner as new employees. The Participant's remaining Spend-Down amount (or a portion thereof) may be applied to the employee's HRA balance according to the provisions set forth in the Summary Plan Description.

### **Article VIII: Plan Administration**

#### **8.01 Allocation of Authority**

The Board of Directors (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator may be one individual or a Committee. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties to:

- (a) Require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;
- (b) Make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;
- (c) Decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;
- (d) Determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer, insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;
- (e) Designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan;
- (f) Keep records of all acts and determinations, and to keep all such records, books of account, data and other documents as may be necessary for the proper administration of the Plan;
- (g) Prepare and distribute to all Employees information concerning the Plan and their rights under the Plan; and
- (h) Do all things necessary to operate and administer the Plan in accordance with its provisions.

#### **8.02 Provision for Third-Party Plan Service Providers**

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan and to rely upon all tables, valuations, certificates, reports, and opinions furnished thereby. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

#### **8.03 Fiduciary Liability**

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

#### **8.04 Compensation of Plan Administrator**

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but the Employer shall pay all reasonable expenses incurred in the performance of their duties.

#### **8.05 Bonding**

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

#### **8.06 Payment of Administrative Expenses**

The Employer currently pays all reasonable expenses incurred in administering the Plan.

## **Article IX: Claims Procedures**

The Plan has established procedures under which a claim for reimbursement under the Plan will be reviewed and appeal procedures in the event a claim for reimbursement is denied. The procedures are set forth in the Summary Plan Description.

## **Article X: Amendment or Termination of Plan**

### **10.01 Permanency**

While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in §§ 10.02 and 10.03 below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

### **10.02 Employer's Right to Amend**

The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Plan Administrator in accordance with its normal procedures for transacting business or, if a Committee, by written consent of all Committee members. Such amendments may apply retroactively or prospectively. Any amendment adopted in accordance with Section 10.02 herein shall be deemed to be approved and adopted by any Affiliated Employer.

### **10.03 Employer's Right to Terminate**

The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

### **10.04 Determination of Effective Date of Amendment or Termination**

Any such amendment, discontinuance, or termination shall be effective as of such date as the Employer shall determine.

## **Article XI: HIPAA Privacy and Security**

### **11.01 Scope and Purpose**

The HRA (the "Plan") will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as set forth below.

### **11.02 Definitions**

For purposes of this Article, the following definitions shall apply:

- (a) "**Breach**" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule that compromises the security or privacy of the PHI. A Breach does not include:
  - (i) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure;
  - (ii) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or
  - (iii) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
- (b) "**Electronic Protected Health Information**" or "**Electronic PHI**" means PHI that is transmitted by or maintained in electronic media.
- (c) "**Health Care Operations**," as defined under 45 C.F.R. Section 164.501, means any of the following activities to the extent that they are related to the Health Plan's covered functions:

- (i) Conducting quality assessment and improvement activities; population-based activities related to health improvement, reduction of health care costs, case management and care coordination; contacting health care providers and patients regarding treatment alternatives; and related functions that do not include treatment;
  - (ii) Reviewing competence or qualifications of health care professionals and evaluating provider and Health Plan performance;
  - (iii) Underwriting and other activities that relate to the creation, renewal or replacement of a contract of health insurance or health benefits; and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance);
  - (iv) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
  - (v) Business planning and development, such as cost-management and planning-related analysis related to managing and operating the Health Plan, and development or improvement of coverage policies; and
  - (vi) Business management and general administrative activities, including, but not limited to: (A) management activities related to implementation of and compliance with the requirements of the Privacy Rule; (B) customer service, including the provision of data analyses for the Health Plan sponsor, provided that PHI is not disclosed to the Health Plan sponsor; (C) resolution of internal grievances; (D) due diligence related to the sale, transfer, merger or consolidation of all or part of the Health Plan with another entity directly regulated under the Privacy Rule, or an entity that, following such activity, will be subject to the Privacy Rule; and (E) consistent with applicable requirements of the Privacy Rule, creating de-identified information, as defined in 45 C.F.R. Section 164.514(b)(2), or a limited data set, as defined under 45 C.F.R. Section 164.514(d)(2).
- (d) “Health Plan” means each “group health plan,” as defined in 45 C.F.R. Section 160.103, sponsored by the Employer to provide health care benefits for its employees, former employees and dependents, including this Plan. The Plan Administrator intends this Plan to form part of an Organized Health Care Arrangement, as defined in 45 C.F.R. §160.103, along with any other benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Employer.
- (e) “Payment,” as defined under 45 C.F.R. Section 164.501, means activities undertaken by the Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care. Such activities include, but are not limited to:
- (i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
  - (ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
  - (iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance) and related health care data processing;
  - (iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;
  - (v) Utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services; and
  - (vi) Disclosure to consumer reporting agencies of necessary information relating to collection of premiums or reimbursement.
- (f) “Privacy Policy” means the Employer’s internal HIPAA privacy and security policies and procedures.
- (g) “Protected Health Information” or “PHI” means individually identifiable health information that (i) relates to the past, present or future physical or mental condition of a current or former Participant, provision of health care to a Participant, or payment for such health care; (ii) can either identify the Participant, or there is a reasonable basis to believe the information can be used to identify the Participant; and (iii) is received, created, maintained or transmitted by or on behalf of the Health Plan.
- (h) “Responsible Employee” means an employee (including a contract, temporary or leased employee) of the Health Plans or of the Employer whose duties (A) require that the employee have access to PHI for purposes of Health Plan Payment or Health Care Operations; or (B) make it likely that he will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 8.03. A Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates, receives, maintains or transmits PHI on behalf of the Health Plan, even though his duties do not (or are not expected to) include creating, receiving, maintaining or

transmitting PHI. Responsible Employees are within the Employer's HIPAA firewall when they perform Health Plan functions.

- (i) "Security Incident" as defined under 45 C.F.R. Section 164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- (j) "Security Rule" means the regulations issued under HIPAA concerning the security of Electronic PHI.

### 11.03 Responsible Employees

Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a Health Plan. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health Plan administration functions that the Employer performs on behalf of a Health Plan pursuant to Section 8.04.

- (a) Employer employees who perform the following functions on behalf of the Health Plans are Responsible Employees:
  - (i) claims determination and processing functions;
  - (ii) Health Plan vendor relations functions;
  - (iii) benefits education and information functions;
  - (iv) Health Plan administration activities;
  - (v) legal department activities;
  - (vi) Health Plan compliance activities;
  - (vii) information systems support activities;
  - (viii) internal audit functions; and
  - (ix) human resources functions.
- (b) In addition to those individuals described in subsection (a), the Administrator who performs claims appeals and other decision-making functions on behalf of the Health Plans, the Health Plans' HIPAA privacy officer and security official, and Employer employees to whom the Health Plans' HIPAA privacy officer and security official has delegated any of the following responsibilities shall also be Responsible Employees:
  - (i) implementation, interpretation and amendment of the Privacy Policy;
  - (ii) Privacy Rule or Security Rule training for Employer employees;
  - (iii) investigation of and response to complaints by Participants and/or employees;
  - (iv) preparation and maintenance of the Health Plans' privacy notice;
  - (v) distribution of the Health Plans' privacy notice;
  - (vi) response to requests by Participants to inspect or copy PHI;
  - (vii) response to requests by Participants to restrict the use or disclosure of their PHI;
  - (viii) response to requests by Participants to receive communications of their PHI by alternate means or in an alternate manner;
  - (ix) amendment and response to requests to amend Participants' PHI;
  - (x) response to requests by Participants for an accounting of disclosures of their PHI;
  - (xi) response to requests for information by the Department of Health and Human Services;
  - (xii) approval of disclosures to law enforcement or to the military for government purposes;
  - (xiii) maintenance of records and other documentation required by the Privacy Rule or Security Rule;
  - (xiv) negotiation of Privacy Rule and Security Rule provisions and/or reasonable security provisions into contracts with third party service providers;
  - (xv) maintenance of Health Plan PHI or Electronic PHI security documentation; or
  - (xvi) approval of access to Electronic PHI.

### 11.04 Permitted Uses and Disclosures

Responsible Employees may access, request, receive, use, disclose, create and/or transmit PHI only to perform certain permitted and required functions on behalf of the Health Plan, consistent with the Privacy Policy. This includes:

- (a) uses and disclosures for the Health Plans' own Payment and Health Care Operations functions;

- (b) uses and disclosures for another Health Plan's Payment and Health Care Operations functions;
- (c) disclosures to a health care provider, as defined under 45 C.F.R. Section 160.103, for the health care provider's treatment activities;
- (d) disclosures to the Employer, acting in its role as Plan Sponsor, of (i) summary health information for purposes of obtaining health insurance coverage or premium bids for the Health Plan or for making decisions to modify, amend or terminate the Health Plan; or (ii) enrollment or disenrollment information;
- (e) disclosures of a Participant's PHI to the Participant or his personal representative, as defined under 45 C.F.R. Section 164.502(g);
- (f) disclosures to a Health Plan for the other Health Plan's Payment or Health Care Operations activities;
- (g) disclosures to a Participant's family members or friends involved in the Participant's health care or payment for the Participant's health care, or to notify a Participant's family in the event of an emergency or disaster relief situation;
- (h) uses and disclosures to comply with workers' compensation laws;
- (i) uses and disclosures for legal and law enforcement purposes, such as to comply with a court order;
- (j) disclosures to the Secretary of Health and Human Services to demonstrate the Health Plan's compliance with the Privacy Rule or Security Rule;
- (k) uses and disclosures for other governmental purposes, such as for national security purposes;
- (l) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
- (m) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;
- (n) uses and disclosures required by other applicable laws; and
- (o) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 C.F.R. Section 164.508.

Notwithstanding anything in the Plan to the contrary, the use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal or replacement of a contract of health insurance.

### **11.05 Certification Requirement**

The Health Plan shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

- (a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;
- (b) to take reasonable steps to ensure that any agents, including subcontractors, to whom the Employer provides PHI or Electronic PHI, received from the Health Plan agree:
  - (i) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and
  - (ii) implement reasonable and appropriate security measures to protect such Electronic PHI.
- (c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;
- (d) to report to the Health Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 8.04A, or any Security Incident, of which the Employer becomes aware;
- (e) to make available PHI for inspection and copying in accordance with 45 C.F.R. Section 164.524;
- (f) to make available PHI for amendment, and to incorporate any amendments to PHI in accordance with 45 C.F.R. Section 164.526;
- (g) to make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;
- (h) to make its internal practices, books and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with the Privacy Rule or the Security Rule;
- (i) if feasible, to return or destroy all PHI and Electronic PHI, received from the Health Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI when no longer needed for the purpose for

which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible and Electronic PHI;

- (j) to take reasonable steps to ensure that there is adequate separation between the Health Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and
- (k) to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic PHI that the Employer creates, receives, maintains or transmits on behalf of the Health Plan.

### **11.06 Mitigation**

In the event of non-compliance with any of the provisions set forth in this Article:

- (a) The HIPAA privacy officer or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy officer or security official, as appropriate, first will investigate the complaint and document his investigation efforts and findings.
- (b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy officer and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.
- (c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

### **11.07 Breach Notification**

Following the discovery of a Breach of unsecured PHI, the Health Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 C.F.R. Section 164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 C.F.R. Section 164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, Health Plan shall notify the media in accordance with 45 C.F.R. Section 164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

## **Article XII: General Provisions**

### **12.01 Not an Employment Contract**

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

### **12.02 Applicable Laws**

The provisions of the Plan shall be construed, administered, and enforced according to applicable Federal law and the laws of the state of incorporation of the Employer to the extent not preempted.

### **12.03 Post-Mortem Payments**

Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving spouse (if any), otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

### **12.04 Non-alienation of Benefits**

Except as expressly provided by the Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

### **12.05 Mental or Physical Incompetency**

Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

### **12.06 Inability to Locate Payee**

If the Plan Administrator is unable to make payment to any Participant or other person under the Plan because he cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited after a reasonable time after the date any such payment first became due.

#### **12.07 Requirement for Proper Forms**

All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

#### **12.08 Source of Payments**

The Employer and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

#### **12.09 Multiple Functions**

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

#### **12.10 Tax Effects**

Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any Pre-tax Premiums made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If, for any reason, it is determined that any amount paid for the benefit of a Participant or Beneficiary is includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof.

#### **12.11 Gender and Number**

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

#### **12.12 Headings**

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

#### **12.13 Incorporation by Reference**

The actual terms and conditions of the Group Health Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

#### **12.14 Severability**

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

#### **12.15 Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

## APPENDIX

### Attachment 1: Summary Plan Description