SCHUYLER COMMUNITY SCHOOLS HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

I
ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan? 2
2. When is My Entry Date? 2
3. Are There Any Employees Who Are Not Eligible? 2

II
BENEFITS

1. What Benefits Are Available? 2
2. When Will I Receive Payment From the Plan? 3
3. Family and Medical Leave Act (FMLA) 3

III
GENERAL INFORMATION

1. General Plan Information 3
2. Employer Information 4
3. Plan Administrator Information 4
4. Third Party Claims Administrator Information 4
5. Service of Legal Process 4
6. Type of Administration 5

IV
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA 5
2. How to Submit a Claim 6

HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

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

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

I
ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan?

You must be an Early Retiree, as defined by the Plan Administrator, in order to be eligible under this Plan.

2. When is My Entry Date?

You will be eligible to join the plan as of your date of retirement.

3. Are There Any Employees Who Are Not Eligible?

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

-- Employees who are not Early Retirees, as defined by the Plan Administrator.

II
BENEFITS

1. What Benefits Are Available?

The plan allows you to be reimbursed for certain out-of-pocket medical, dental and vision expenses which are incurred by you and your dependents. The expenses, which qualify, are those permitted by Section 213 of the Internal Revenue Code.

The plan allows you to be reimbursed by the Employer for any health or dental insurance premiums, which are incurred by you or your dependents.

The maximum allowed each year is $3,333, plus any unused amounts from prior Coverage Periods. This amount will be available every September. However, the maximum that can be carried forward to a later Coverage Period is $10,000.

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage.

2. When Will I Receive Payments From the Plan?

During the course of the Coverage Period, you may submit requests for reimbursement of expenses you have incurred. Request for reimbursement can be made for up to five (5) years beginning in the first September following your date of retirement. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

3. Family and Medical Leave Act (FMLA)

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

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

III
GENERAL INFORMATION ABOUT OUR PLAN

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

1. General Plan Information

Schuyler Community Schools Health Reimbursement Arrangement is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your Plan become effective on July 1, 2010.

2. Employer Information

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

Schuyler Community Schools
401 Adam Street
Schuyler, Nebraska 68661
TIN: 47-0535355

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

3. Plan Administrator Information

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

Schuyler Community Schools
401 Adam Street
Schuyler, Nebraska 68661
(402) 362-3527

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

4. Third Party Claims Administrator Information

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

Regional Care, Inc.
905 West 27th Street
Scottsbluff, NE 69361
(308) 635-2260 or (800) 795-7772

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

5. Service of Legal Process

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

6. Type of Administration

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

IV
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) Examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, 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 Employee Benefits Security Administration.

(b) Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

If your claim for a benefit 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.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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 Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

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 the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. How to Submit a Claim

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

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

(2) Complete the Employee portion of the form.

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

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

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

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

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

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

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

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following a denial on review.

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

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

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

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

(1) was relied upon in making the Claim determination;

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

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

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

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

ADOPTION AGREEMENT
FOR
HEALTH REIMBURSEMENT ARRANGEMENT

The undersigned Employer adopts Health Reimbursement Arrangement and elects the following provisions:

EMPLOYER INFORMATION

1. EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER

Name: Schuyler Community Schools

Address: 401 Adam Street
Street

Schuyler (City) Nebraska (State) 68661 (Zip)

Telephone: 402-362-3527

2. EMPLOYER'S TAXPAYER IDENTIFICATION NUMBER: 47-0535355

3. TYPE OF ENTITY

a. [ ] Corporation (including Tax-exempt or Non-profit Corporation)
b. [ ] Professional Service Corporation
c. [ ] S Corporation
d. [ ] Limited Liability Company that is taxed as:
   1. [ ] a partnership or sole proprietorship
   2. [ ] a Corporation
   3. [ ] an S Corporation
e. [ ] Sole Proprietorship or Non-profit Corporation
f. [ ] Partnership (including Limited Liability)
g. [X] Governmental Entity
h. [ ] Other: _____

NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Heath Reimbursement Arrangement.

PLAN INFORMATION

4. PLAN NAME:

Schuyler Community Schools Health Reimbursement Arrangement

5. EFFECTIVE DATE

a. [X] This is a new Health Reimbursement Arrangement effective as of July 1, 2010 (hereinafter called the "Effective Date").
b. [ ] This is an amendment and restatement of a previously established Health Reimbursement Arrangement of the Employer which was originally effective _____ (hereinafter called the "Effective Date"). The effective date of this amendment and restatement is _____.

6. NUMBER assigned by the Employer

a. [X] 501
b. [ ] 502
c. [ ] 503
d. [ ] Other: _____

7. PLAN ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:
(If none is named, the Employer will become the Administrator.)
a. [X] Employer (Use Employer address and telephone number).
b. [ ] Use name, address and telephone number below:

Name: _____

Address: _____
Street

_____ _____ _____
City State Zip

Telephone: _____

8. CLAIMS ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:
(If none is named, the Employer will serve as the Claims Administrator.)
a. [ ] Employer (Use Employer address and telephone number).
b. [X] Use name, address and telephone number below:

Name: Regional Care, Inc.

Address: 905 West 27th Street
Street

Scottsbluff Nebraska 69361
City State Zip

Telephone: (308) 635-2260 or (800) 795-7772

ELIGIBILITY REQUIREMENTS

9. ELIGIBLE EMPLOYEES
a. [ ] N/A. No exclusions.
b. [ ] The following are excluded (select all that apply):
1. [ ] Union Employees
2. [ ] Non-resident aliens
3. [ ] Employees who are not eligible for the Employer's group medical plan
4. [ ] Salaried Employees
5. [ ] Hourly Employees
6. [ ] Leased Employees
7. [ ] Part-Time Employees scheduled to work at least _____ hours per week.
8. [X] Other: **Any Employee who is not an Early Retiree**

10. THE FOLLOWING AFFILIATED EMPLOYERS will adopt this Health Reimbursement Arrangement as Participating Employers (if there is more than one, or if Affiliated Employers adopt this after the date the Adoption Agreement is executed, attach a list to this Adoption Agreement of such Affiliated Employers including their names, addresses and taxpayer identification numbers):
a. [X] N/A
b. [ ] Name of Affiliated Employer (s): _____

11. CONDITIONS OF ELIGIBILITY
Any Eligible Employee will be eligible to participate in the Health Reimbursement Arrangement upon satisfaction of the following:
a. [ ] Date of Hire (No service required)
b. [ ] Same conditions as Employer's group medical plan
c. [ ] _____ years after date of hire
d. [ ] _____months after date of hire
e. [ ] _____days after date of hire
f. [X] Other: date of retirement

12. EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee who has satisfied the eligibility requirements will become a Participant on

a. [X] the day on which such requirements are satisfied.
b. [ ] the first day of the month coinciding with or next following the date on which such requirements are satisfied.
c. [ ] the first day of the calendar quarter coinciding with or next following the date on which such requirements are satisfied.
d. [ ] the first day of the pay period coinciding with or next following the date on which such requirements are met.
e. [ ] the first day of the Coverage Period coinciding with or next following the date on which such requirements are satisfied.
f. [ ] same date as Employer's group medical plan.
g. [ ] Other: _____

BENEFITS

13. MAXIMUM BENEFIT PER COVERAGE PERIOD:

a. [X] $3,333
b. [ ] Other:_____

14. COVERAGE PERIOD is:

a. [ ] monthly
b. [ ] quarterly
c. [ ] yearly
d. [X] Other: The Maximum Benefit is available yearly in September for the first 3 years after date of retirement.

15. THIS ARRANGEMENT SHALL REIMBURSE: (select all that apply)

a. [ ] co-payments under the Employer's group medical plan
b. [ ] deductibles under the Employer's group medical plan
c. [X] all medical expenses within the meaning of Code Section 213, including non-prescription drugs
d [X] medical insurance premiums
e [ ] dental, vision and preventative care only or expenses in excess of the deductible (HSA also provided) with the following further limitations:_____
f [ ] the following types of medical expenses ONLY:_____
_____
g. [ ] Other:_____

16 IF THE EMPLOYER MAINTAINS A HEALTH FLEXIBLE SPENDING ACCOUNT, WHICH PLAN SHALL PAY EXPENSES FIRST?

a. [X] N/A. The Employer does not maintain a Health Flexible Spending Account and/or Cafeteria Plan.
b. [ ] This Plan (Heath Reimbursement Arrangement).
c. [ ] The Health Flexible Spending Account under the Employer's Cafeteria Plan.

17. IS THE EMPLOYER SUBJECT TO THE FAMILY AND MEDICAL LEAVE ACT?

If b. is selected, FMLA will not apply

a. [X] Yes.
b. [ ] No.

18. IS THE PLAN SUBJECT TO COBRA?

If b. is selected, COBRA will not apply

a. [ ] Yes.
b. [X] No.

19. CARRY FORWARD: Amounts not used during a Coverage Period shall:

a. [X] Be carried forward to the next Coverage Period, in an amount up to $10,000.
b. [ ] Shall be forfeited.

20. A CLAIM may be submitted up to **5 years**
    a. [ ] the end of the Coverage Period
    b. [ ] the end of each calendar year
    c. [X] Other: beginning on the first September following the date of retirement.

21. DEBIT/CREDIT CARDS shall be provided by the Employer for Medical Expenses:
    a. [ ] Yes
    b. [X] No

22. HEALTH SAVINGS ACCOUNT provided by the Employer:
    a. [ ] Yes
    b. [X] No

This Adoption Agreement may be used only in conjunction with The Health Reimbursement Arrangement Basic Plan Document. This Adoption Agreement and the Health Reimbursement Arrangement document shall together be known as Health Reimbursement Arrangement.

EMPLOYER

By: _____

PARTICIPATING EMPLOYER (if applicable)

By: _____

PARTICIPATING EMPLOYER (add additional signature lines as necessary):

By: _____

SCHUYLER COMMUNITY SCHOOLS HEALTH REIMBURSEMENT ARRANGEMENT

BASIC PLAN DOCUMENT

08/01/05

TABLE OF CONTENTS

ARTICLE I
DEFINITIONS

1.1 Administrator 1
1.2 Affiliated Employer 1
1.3 Code 1
1.4 Coverage Period 1
1.5 Dependent 1
1.6 Effective Date 1
1.7 Eligible Employee 1
1.8 Employee 2
1.9 Employer 2
1.10 Employer Contribution 2
1.11 ERISA 2
1.12 Leased Employee 2
1.13 Participant 2
1.14 Plan 3
1.15 Premiums 3
1.16 Qualifying Medical Expenses 3

ARTICLE II
PARTICIPATION

2.1 Eligibility 3
2.2 Effective Date of Participation 3
2.3 Termination of Participation 4

ARTICLE III
BENEFITS

3.1 Establishment of Plan 4
3.2 Nondiscrimination Requirements 4
3.3 Health Reimbursement Arrangement Claims 5
3.4 Debit and Credit Cards 5

ARTICLE IV
ERISA PROVISIONS

4.1 Claim for Benefits 7
4.2 Named Fiduciary 9
4.3 General Fiduciary Responsibilities 9
4.4 Nonassignability of Rights 9

ARTICLE V
ADMINISTRATION

5.1	Plan Administration	10
5.2	Examination of Records	10
5.3	Indemnification of Administrator	11

ARTICLE VI
AMENDMENT OR TERMINATION OF PLAN

6.1	Amendment	10
6.2	Termination	11

ARTICLE VII
MISCELLANEOUS

7.1	Plan Interpretation	11
7.2	Gender and Number	11
7.3	Written Document	11
7.4	Exclusive Benefit	12
7.5	Participant's Rights	12
7.6	Action by the Employer	12
7.7	No Guarantee of Tax Consequences	12
7.8	Indemnification of Employer by Participants	12
7.9	Funding	13
7.10	Governing Law	13
7.11	Severability	13
7.12	Headings	13
7.13	Continuation of Coverage	13
7.14	Family and Medical Leave Act	13
7.15	Health Insurance Portability and Accountability Act	13
7.16	Uniformed Services Employment and Reemployment Rights Act	14
7.17	HIPAA Privacy Standards	14
7.18	HIPAA Electronic Security Standards	16

Certificate of Adopting Resolution 19

HEALTH REIMBURSEMENT ARRANGEMENT

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

ARTICLE I
DEFINITIONS

1.1 "Administrator" means the individual(s) or committee appointed by the Employer to carry out the administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

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

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

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

1.5 "Dependent" means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). Any child of a Participant who is an "alternate recipient" under a qualified medical child support order under ERISA Section 609 shall be considered a Dependent under this Arrangement.

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

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

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

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

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

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

1.11 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.12 "Leased Employee" means, effective with respect to Plan Years beginning on or after January 1, 1997, any person (other than an Employee of the recipient Employer) who, pursuant to an agreement between the recipient Employer and any other person or entity ("leasing organization"), has performed services for the recipient (or for the recipient and related persons determined in accordance with Code Section 414(n)(6)) on a substantially full time basis for a period of at least one year, and such services are performed under primary direction or control by the recipient Employer. Contributions or benefits provided a Leased Employee by the leasing organization which are attributable to services performed for the recipient Employer shall be treated as provided by the recipient Employer. Furthermore, Compensation for a Leased Employee shall only include Compensation from the leasing organization that is attributable to services performed for the recipient Employer.

A Leased Employee shall not be considered an employee of the recipient Employer if: (a) such employee is covered by a money purchase pension plan providing: (1) a nonintegrated employer contribution rate of at least ten percent (10%) of compensation, as defined in Code Section 415(c)(3), but for Plan Years beginning prior to January 1, 1998, including amounts contributed pursuant to a salary reduction agreement which are excludable from the employee's gross income under Code Sections 125, 402(e)(3), 402(h)(1)(B), 403(b), or for Plan Years beginning on or after January 1, 2001 (or as of a date, no earlier than January 1, 1998, as specified in an addendum to the Adoption Agreement), 132(f)(4), (2) immediate participation, and (3) full and immediate vesting; and (b) leased employees do not constitute more than twenty percent (20%) of the recipient Employer's nonhighly compensated workforce.

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

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

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

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

ARTICLE II
PARTICIPATION

2.1 Eligibility

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

2.2 Effective Date of Participation

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

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

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

2.3 Termination of Participation

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

ARTICLE III
BENEFITS

3.1 Establishment of Plan

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

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

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

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

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

3.2 Nondiscrimination Requirements

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

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

3.3 Health Reimbursement Arrangement Claims

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

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

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

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

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

3.4 Debit and Credit Cards

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

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

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

(d) The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth on the Adoption Agreement.

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

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

- **(i)** Co-payments for doctor and other medical care;
- **(ii)** Purchase of drugs;
- **(iii)** Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(g) Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a merchant or service provider describing the service or product, the date of the purchase and the amount. Some charges shall be considered substantiated at the time of charge by the nature of the charge, such as co-payments. Some charges shall be considered substantiated due to their "recurring" nature, in which the expenses match expenses previously approved as to amount, provider, and time period. At point of sale, the service provider or merchant can provide information to the Administrator to substantiate the charge. All charges shall be conditional pending confirmation and substantiation.

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

- **(i)** Repayment of the improper amount by the Participant;

~~(i)~~

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

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

ARTICLE IV
ERISA PROVISIONS

4.1 Claim for Benefits

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

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

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

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

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

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

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review.

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

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

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

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

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

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

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

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

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

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

4.2 Named Fiduciary

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

4.3 General Fiduciary Responsibilities

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

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

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

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

4.4 Nonassignability of Rights

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

ARTICLE V
ADMINISTRATION

5.1 Plan Administration

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

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

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

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

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

(e) To approve reimbursement requests and to authorize the payment of benefits; and

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

(g) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.

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

5.2 Examination of Records

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

5.3 Indemnification of Administrator

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

ARTICLE VI
AMENDMENT OR TERMINATION OF PLAN

6.1 Amendment

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

6.2 Termination

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

ARTICLE VII
MISCELLANEOUS

7.1 Plan Interpretation

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

7.2 Gender and Number

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

7.3 Written Document

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

7.4 Exclusive Benefit

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

7.5 Participant's Rights

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

7.6 Action by the Employer

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

7.7 No Guarantee of Tax Consequences

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

7.8 Indemnification of Employer by Participants

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

7.9 Funding

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

7.10 Governing Law

This Plan and Trust shall be construed and enforced according to the Code, ERISA, and the laws of the state or commonwealth in which the Employer's principal office is located (unless otherwise designated in the Adoption Agreement), other than its laws respecting choice of law, to the extent not pre-empted by ERISA.

7.11 Severability

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

7.12 Headings

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

7.13 Continuation of Coverage

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each qualified beneficiary (as defined in Code Section 4980B) will be entitled to continuation coverage as prescribed in Code Section 4980B.

7.14 Family and Medical Leave Act

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

7.15 Health Insurance Portability and Accountability Act

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

7.16 Uniformed Services Employment and Reemployment Rights Act

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

7.17 HIPAA Privacy Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.18 HIPAA Electronic Security Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CERTIFICATE OF ADOPTING RESOLUTION

The undersigned Principal of _____ (the Employer) hereby certifies that the following resolutions were duly adopted by the board on_____, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the Health Reimbursement Arrangement effective _____, presented to this meeting is hereby approved and adopted and that the proper officers 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.

The undersigned further certifies that attached hereto is a true copy of the Health Reimbursement Arrangement and the Summary Plan Description approved and adopted in the foregoing resolutions.

_____

Employer

Date: _____