SUMMARY PLAN DESCRIPTION (SPD)
for the
HEALTHCARE REIMBURSEMENT ACCOUNT PLAN (HRA)

The Employer named below also serves as Plan Administrator:
The City of Dardenne Prairie
2032 Hanley RD
Dardenne Prairie, MO 63368
The Employer accepts service of legal process.

Federal Tax ID: 43-1493121

ERISA Plan Number: 525

Plan Name: The City of Dardenne Prairie Healthcare Reimbursement Account Plan (HRA)

Group Name, if applicable: N/A

Plan Effective Date: 01/01/2025

Plan Year: 01/01 to 12/31

Run Out - Number of Days: 90 days

HRA Plan Design:
HRA Benefits: Benefits allowed for reimbursement: Medical Deductible Expenses
HRA Deductible: No

HRA Payout Tiers
Single Maximum Payout: $5,000.00
Single+1 Maximum Payout: $10,000.00
Family Maximum Payout: $15,000.00
By-Member
Percent Pay out: 100%

Rollover Allowed with applicable limit: N/A

Waiting Period: 0 (not to exceed 90 days)

EBHRA: No
If this HRA is an Excepted Benefit HRA (EBHRA) see details below.

ICHRA: No
If this HRA is an Individual Coverage HRA (ICHRA) see details below.

QSEHRA: No
If this HRA is a Qualified Small Employer HRA (QSEHRA) see details below.

Spousal Incentive HRA: No
If this HRA is a Spousal Incentive HRA (SIHRA) see details below.

'You' and 'Your' refers to an Employee who has been enrolled by the Employer as a Participant in this HRA for the current Plan Year, or has a Carryover balance from the prior Plan Year when a Carryover is allowed as indicated above.

Purpose. Your Employer has adopted this HRA under Internal Revenue Code Section 105 Accident and Health Plans, to pay for medical care as defined in Code Section IRS Code Section 213(d), which is rendered or received during the Plan Year for You, Your spouse, and Your dependents. The employer funds this Plan out its general assets.

This SPD expressly incorporates by reference the Enrollment Materials provided by Your Employer at the time of enrollment.

All healthcare expenses must be (a) for medical care as defined in Code Section 213(d), which is rendered or received during the Plan Year, (b) incurred by a Participant, Participant's enrolled spouse, or enrolled dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan.

The Participant Reference Guide. The Participant Reference Guide which is incorporated by express reference into this SPD includes all the information You need to access Your HRA and submit requests for reimbursement. By signing into Your online account, You will have access to information about Your enrollment, available funds, total contributions, and total reimbursements.

Enrollment. An Employee's right to enroll in and maintain coverage under the Employer's group health plan and this HRA are described in detail in the Enrollment Materials provided by the Employer, including:

1) Under what circumstances a spouse, dependents and other persons may be enrolled including any proof of a relationship needed to meet the eligibility requirements (note that group health plans are required to cover dependent children placed with a participant for adoption under the same terms and conditions as apply in the case of dependent children who are Your natural children);
2) The existence of any waiting periods and how they are applied;
3) When enrollment is allowed and a description of the enrollment procedures;
4) When coverage will be effective and when it will end including the events that can occur that will terminate coverage; and,
5) Details regarding when special enrollment rights allowing individuals who previously declined health coverage for themselves and their dependents have an opportunity to enroll (regardless of any open enrollment period). The Special Enrollment Notice, a copy of which was previously furnished to each participant, also contains important information about the potential special enrollment rights including a 30-day time limit for requesting the enrollment. You can contact Your Benefits Coordinator to receive an additional copy of that notice.
6) Details regarding when special enrollment rights for an employee who is eligible, but not enrolled for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) when either:
   (a) The employee or dependent were covered under a Medicaid plan or under a State Child Health Plan (SCHIP) and that coverage is terminated as a result of loss of eligibility; or,
   (b) The employee or dependent becomes eligible for premium assistance from Medicaid or SCHIP (including assistance under any waiver or demonstration project conducted under or in relation to Medicaid or SCHIP).

Participant Termination. You will automatically cease to be a participant on the date of, or the last day of the month in which the following events occur:

1) Your death,
2) This HRA terminates,
3) You are no longer an Employee,
4) The Employer determines You made fraudulent or improper use of a plan,
5) For HRA plans that require enrollment in the Employers Group Health Plan, the date You lose coverage under that Employers Group Health Plan,
6) The day You opt-out of coverage under this HRA Plan. (Not applicable to a (QSEHRA). You can opt-out of HRA coverage at each annual open enrollment or if retiree benefits are provided under this HRA Plan, You can opt-out the day You terminate employment, or
7) For coverage under the Individual Coverage HRA (ICHRA), the Participant no longer maintains ICHRA-compatible individual health insurance.

Upon termination, a Participant can submit claims for coverage incurred prior to the termination date as long as they are submitted on or before the Run Out End Date.

Check with Your Employer for Your actual coverage end date.

For Qualified Small Employer HRAs and other applicable HRAs that pro-rate the annual benefit provided under the Plan, You are subject to proration of the annual HRA benefit if You are not covered under the Plan for the entire 12-month Plan Year. Additionally, You must provide sufficient proof of Minimum Essential Coverage (MEC) to receive benefits under the Plan.

Excepted Benefit HRA (EBHRA) - This SPD indicates whether this HRA is an EBHRA. If indicated as an EBHRA on this SPD, Your Employer intends this Plan to comply with Treasury Regulation Health Reimbursement Arrangements and Other Account-Based Group Health Plans (Fed Reg. 28888). This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and is a Group Health Plan as defined in ERISA. An EBHRA is not subject to Public Health Service Act (PHSA) mandates included in the Affordable Care Act (ACA) or Health Insurance Portability and Accountability Act's (HIPAA's) portability and nondiscrimination rules. An EBHRA is subject to HIPAA's administrative simplification requirements including the HIPAA privacy and security rules.

If You are an Eligible Employee, as defined below, You shall automatically become a Participant in an EBHRA upon successful completion of the Waiting Period indicated on the first page of this SPD (not to exceed 90 days). As an Eligible Employee, you must be eligible for other nonexcepted, non-account-based group health plan coverage sponsored by the Employer for the plan year. However, as an Eligible Employee You do not need to enroll in such coverage. The following persons are excluded from participating in this Plan and are not Eligible Employees:

(a) Employees not eligible for other employer sponsored nonexcepted, non-account-based group health plan coverage for the plan year.
(b) Employees offered and/or enrolled in an Individual Coverage Health Reimbursement Arrangement.

All other Employees are considered Eligible Employees.

Individual Coverage HRA (ICHRA) – This SPD indicates whether this HRA is an ICHRA. If indicated as an ICHRA on this SPD, Your Employer intends this Plan to be an ICHRA under the Treasury Regulation regarding Health Reimbursement Arrangements and Other Account-Based Group Health Plans (Fed Reg. 28888), in compliance with Sections 105 and 106 of the Internal Revenue Code of 1986 and shall be interpreted to accomplish that objective. In accordance with the forgoing, the cost of benefits provided pursuant to this Plan are intended to be eligible for deduction by Your Employer and exclusion from the Your gross income. This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and is a Group Health Plan as defined in ERISA. This Plan is subject to continuation rights, i.e. the Consolidated

Omnibus Budget Reconciliation Act (COBRA). This Plan is subject to the Public Health Service Act mandates included in the Affordable Care Act.

You will automatically cease to be a Participant on the date on which You no longer maintain ICHRA-compatible individual health insurance. If You have group health coverage, including a spouse's group health plan, You are not eligible. You will be afforded a special enrollment period in which to obtain coverage when coming on to the ICHRA or changing plans on an annual basis.

You must be enrolled in ICHRA-compatible individual health insurance (or Medicare coverage) for each month the employee (or if applicable, Your family member) is covered by this ICHRA. This can be individual health insurance including coverage purchased on an Exchange. This insurance cannot be coverage consisting solely of vision, dental, or similar excepted benefits. TRICARE, which is coverage, offered by the Department of Defense to active and retired military personnel, is not considered ICHRA-compatible coverage. Therefore, You may not enroll in the Individual Coverage HRA and TRICARE without enrolling in an individual health insurance policy (or Medicare). The ICHRA-compatible individual health insurance plan is not an employer sponsored group health plan, it is not subject to ERISA, and no continuation of coverage after termination is required under federal or state law.

You must furnish a written acknowledgement to Your Employer or its Service Provider that You are covered under a compatible individual health insurance plan in a format provided by the Employer. The Plan becomes effective for You on the day that the first claim for premium is filed. You must certify ongoing enrollment at the time of each premium payment requested from this Plan.

Qualified Small Employer HRA (QSEHRA) - This SPD indicates whether this HRA is a QSEHRA. If indicated as a QSEHRA on this SPD, Your Employer intends this Plan to be a QSEHRA under The Cures Act of 2016 and in compliance with Sections 105 and 106 of the Internal Revenue Code of 1986 and shall be interpreted to accomplish that objective. In accordance with the forgoing, the cost of benefits provided pursuant to this Plan are intended to be eligible for deduction by Your Employer and exclusion from Your gross income. This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), however it is not a Group Health Plan as defined in ERISA. This Plan is not subject to any continuation rights such as the Consolidated Omnibus Budget Reconciliation Act (COBRA). This Plan is not subject to the Public Health Service Act mandates included in the Affordable Care Act.

As an Eligible Employee You shall automatically become a Participant in this Plan upon successful completion of the Waiting Period indicated on the first page of the SPD (not to exceed 90 days). You will automatically cease to be a Participant on the earliest of the following dates: the date on which this Plan is terminated by Your Employer or the date on which the Your employment with Plan Sponsor is terminated, whether termination is initiated by the You or Your Plan Sponsor.

Spousal Incentive HRA (SIHRA) - This SPD indicates whether this HRA is a Spousal Incentive HRA (SIHRA). If indicated as a Spousal Incentive HRA, Your Employer intends this Plan to be a SIHRA and to comply with Treasury Regulation Health Reimbursement Arrangements and Other Account-Based Group Health Plans (Fed Reg. 28888). This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and is a Group Health Plan as defined in ERISA. An SIHRA is subject to Public Health Service Act (PHSA) mandates included in the Affordable Care Act (ACA) and Health Insurance Portability and Accountability Act's (HIPAA's) portability and nondiscrimination rules. An SIHRA is subject to HIPAA's administrative simplification requirements including the HIPAA privacy and security rules.

If You are an Eligible Employee, as defined below, You shall become a Participant in an SIHRA upon successful completion of the Waiting Period indicated on the first page of this SPD (not to exceed 90 days). As an Eligible Employee, you and your spouse and dependent children must be eligible for other nonexcepted, non-account-based group health plan coverage sponsored by Your spouse's employer for the plan year.

Requirements for participation in this plan are:

(a) As an Eligible Employee You will need to enroll in Your spouse's employer's group health plan as defined above.
(b) You will be excluded from participating in this SIHRA and will not be considered an Eligible Employee for the SIHRA if Your spouse is not eligible under their employer's sponsored nonexcepted, non-account-based group health plan coverage for the SIHRA plan year.
(c) Your spouse will need to enroll in their employer's group health plan as defined above.
(d) Any dependent children currently enrolled under your employer's group health plan will need to enroll in the spouse's employer's group health plan.

You and/or, your spouse and your dependents will automatically cease to be a Participant in the SIHRA on the date on which Your spouse no longer maintains coverage for You, your spouse and your dependents (if applicable). You must be enrolled in Your spouse's compatible employer-sponsored group health insurance for each month You, Your spouse and your Dependents (if applicable) are covered by this SIHRA. Your spouse's employer-sponsored health insurance cannot be coverage consisting solely of vision, dental, or similar excepted benefits.

You must furnish a written acknowledgement to Your Employer or its Service Provider that You, Your spouse and/or Your dependents (if applicable) are covered under Your spouse's employer's nonexcepted, non-account based group health plan in a format provided by the Employer. The Plan becomes effective for You on the day that You, Your spouse and/or dependents become covered under Your spouse's employer group health plan. . You must certify ongoing enrollment in Your spouse's employer's plan at the time of each reimbursement requested from this SIHRA.

If Your spouse's coverage ends under their employer's group health plan, coverage under the SIHRA will end and any outstanding claims must be filed before expiration of the runout period. Only those expenses that were incurred prior to Your spouse's loss of coverage under their employer's group health plan will be reimbursed.

Administration. Your Employer acting as the Plan Administrator has sole discretionary powers and is responsible for the administration of this Plan. Should You need to see any records or have any questions regarding these Plans, contact Your Employer. Your Employer has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. The Plan Administrator has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time.

The Plan Administrator appoints TASC as a Service Provider to maintain certain plan records and to be responsible for the plan's day-to-day administration. TASC is not a Plan Administrator and has no discretionary authority regarding the plan.

Family Medical Leave Act. The Family & Medical Leave Act of 1993 (29 U.S.C. 2611) as amended, is referred to as FMLA. FMLA Leave will not be available to Employees for Plan Years in which the Employer has fewer than 50 Employees as counted in that Act. For Plan Years in which the Employer has 50 or more Employees, the Employer is required to make FMLA Leave available to Eligible Employees under circumstances that are prescribed by applicable federal law, including a period in which an Employee is off due to the FMLA shall be treated in accordance with the rules for a layoff or a leave of absence and provided to the extent required by the FMLA (e.g., the employer will continue to pay its share of the contribution to the extent the Participant opts to continue coverage). If the Employer is subject to the FMLA, a Participant may revoke or continue an election through the plan upon commencement of the FMLA Leave, whether such leave is paid or unpaid. This provision applies in addition to any other right to revoke and reelect benefits under the plan. Upon return from FMLA Leave, a Participant may be reinstated to all pre-leave elections.

Qualified Medical Child Support Order (QMCSO). This HRA will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of a Participant in a group health plan; (2) is made pursuant to a state domestic relations law; and (3)

which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits. Participants may obtain, without charge, a copy of the plan's procedures from the Plan Administrator.

Claim Denials. If Your claim is denied in whole or in part, You will be notified in writing within 30 days after the date Your claim is received. This time period may be extended for an additional 15 days for matters beyond our control. TASC will provide written notice of any extension, including the reasons for the extension and the date by which a decision is expected. When a claim is incomplete, the extension notice will also specifically describe the required information needed. You will have 45 days from receipt of the notice in which to provide the specified information. The time for a decision on Your claim will be suspended until the specified information is provided.

Appeals. If Your claim is denied in whole or part, then You (or Your authorized representative) may request review. Your appeal must be made in writing within 180 days after Your receipt of the notice that the claim was denied. If You do not appeal on time, You will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that You feel Your claim should not have been denied. It should include any additional facts and/or documents that You feel support Your claim. You will have the opportunity to ask additional questions and make written comments, and You may review (upon request and at no charge) documents and other information relevant to Your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision On Review. Your appeal will be reviewed and determination made within a reasonable time, defined as not later than 60 days after receipt of Your appeal. If the decision on review affirms the initial denial of Your claim, You will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

- specific reason(s) for the decision on review;
- specific Plan provision(s) on which the decision is based;
- a statement of Your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied on and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to You upon request; and a statement of Your right to bring suit under ERISA §502(a) (where applicable)

ERISA Rights. An Account Plan that reimburses the Accountholder for medical services is subject to the Employee Retirement Income Security Act of 1974 (ERISA). An Account Plan that reimburses only medical premium is not subject to ERISA. Some of Your basic rights under ERISA are described below. Your rights under ERISA and other federal and state law as related to other Qualified Benefit Plans You elected are fully detailed in the Summary Plan Descriptions that are maintained by Your Employer for those plans.

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration [sic Employee Benefits Security Administration]. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. (Not applicable to employers with less than 20 employees or the QSEHRA). Continue health care coverage for Yourself, spouse or dependents if there is a loss of coverage under the plan as a result

of a qualifying event. You or Your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing Your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your group health plan, if You have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from Your group health plan or health insurance issuer when You lose coverage under the plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of creditable coverage, You may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after Your enrollment date in Your coverage.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of You and other plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a (pension, welfare) benefit or exercising Your rights under ERISA.

Enforce Your Rights. If Your claim for a (pension, welfare) 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.

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

Assistance with Your Questions. If You have any questions about Your plan, You should contact the plan administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the plan administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

INTRODUCTION and INSTRUCTIONS

Materials, Use and Limited License
TASC is granting a non-exclusive, non-assignable, limited license to use this Plan Document only in connection with the provisions of the Subscription Services. It is understood that the Plan Document and related materials are the confidential property of TASC, they are not "work for hire", and no additional rights to use the Materials are granted. The Purchaser is responsible for its use and the protection of the confidentiality of Materials and shall be liable for any unauthorized use or disclosure.

Effect of Termination
The terms of the limited license to use this Plan Document continue after the termination of any or all agreements between TASC and the Purchaser.

Instructions
This Plan Document does not stand alone.

- This Plan Document incorporates by reference your Enrollment Materials. Place a copy of your entire enrollment package for each enrollment period, along with any changes that are communicated during the year, in a file with this Plan Document for easy access for participant requests or for an audit.
- This Plan Document refers to the Summary Plan Description for specific details such as the plan year, plan name and other necessary demographics. These instances are spelled out in the Plan Document.
- Any amendment made by competent legal counsel should be attached to this Plan Document. TASC does not need to review such amendments. TASC will have no liability for any losses or penalties related to such amendments.

This Plan Document should be saved each year with a copy of the Summary Plan Description and Enrollment Materials attached for ease in responding to any audits or Participant requests.

Important Notice
This Plan Document is intended as a prototype Plan Document for use with a TASC Subscription Service. TASC and its representatives are not attorneys and do not provide legal advice. Any questions regarding state or local requirements, and any requests for revisions or additional terms should be sent to your benefit advisor or legal counsel.

Adoption
This Plan Document is adopted by the Purchaser by its acts to download and save this Plan Document per these instructions. The Purchaser is advised to inquire internally and follow any and all specific or formal requirements for the adoption of a benefit plan.

PLAN DOCUMENT
For the
HEALTHCARE REIMBURSEMENT ACCOUNT PLAN (HRA)

Article I: Table of Contents

Article II – Adoption and Purpose

2.01 **Adoption and Purpose**. The Employer adopts this Healthcare Reimbursement Plan (HRA), and creates this HRA as defined under IRS Notice 2002-45, under the terms and conditions set forth in this Plan Document as well as under the Enrollment Materials that are expressly incorporated by reference into this Plan Document. The Eligible Medical Expenses reimbursed under this HRA are intended to be eligible for exclusion from Participants' gross income under Code §105(b). This Plan is intended to be an employer-provided medical reimbursement plan under Code §§105 and 106. See Article X for the purpose and specific requirements for an Excepted Benefit HRA.

2.02 **Plan Detail and Demographics**. This Plan Document expressly incorporates by reference the following demographics from the Summary Plan Description: The Plan Name; the Plan Sponsor's name and address; the Plan Administrator's name and address; the Plan Year, the Plan Run Out Date. The Summary Plan Description will indicate whether this is an Excepted Benefit HRA.

2.03 **Funding**. Benefits under this Plan shall be made from the Employer's general assets. Annual allocations designated by the Employer shall be monitored for each enrolled Participant in a manner deemed appropriate by the Employer. There are no segregated funds or Plan assets required or established to maintain this Plan. No Employee contributions are allowed.

Article III – Definitions

3.01 **Code**. The Internal Revenue Code of 1985, as amended from time to time.

3.02 **Dependent**. A Dependent is defined by Section 152(a), including any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). For the purposes of the tax advantages available under Qualified Benefit Plans that provide accident and health benefits as defined under Sections 105 and 106 of the Code, a Dependent is determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof and includes any child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27.

3.03 **Eligible Medical Expenses**. All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Participant, Participant 's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial" to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) products no longer require a prescription and can be reimbursed under this Plan. The Enrollment Materials will include limitations and exclusions to Eligible Medical Expenses, if any.

3.04 **Employee**. A person who is currently or hereafter employed by the Employer, or by any other Employer aggregated under Sections 414(b), (c), (m), (n), or (o) of the Internal Revenue Code and the regulations thereunder, including a leased Employee subject to Section 414(n) of the Code. Excluded are Employees who are non-resident aliens and receive no earned income from the employer, which constitutes income from sources within the United States, and . self-employed individuals as described in section 401(c) of the Internal Revenue Code including sole proprietors, or partners in a partnership.

3.05 **Employer**. The Employer adopting this plan and any affiliate or subsidiary that, with the consent of the Employer becomes an Employer, by adopting the plan, or any successor business organization that assumes the obligations of the Employer.

3.06 **Enrollment Materials.** The Employer will provide written Enrollment Materials at each enrollment period and during the Plan Year for midyear enrollees. The Enrollment Materials will provide the specific process for enrollment in the Qualified Benefits Plans. The Enrollment Materials are expressly incorporated by reference into this Plan Document.

3.07 **Participant**. Any employee who has met the eligibility requirements set forth in the Enrollment Materials and Summary Plan Description.

3.08 **Plan Year.** Commencing on the first day of the Plan Year and each anniversary thereof, except that the first Plan Year may include a period of fewer than twelve (12) consecutive months.

3.09 **Spouse**. Any individual who is legally married to a Participant under applicable state law.

Article IV – Eligibility and Participation

4.01 **Eligibility Requirements**. Each employee shall be eligible to participate in this HRA upon meeting the eligibility requirements outlined in the Enrollment Materials. An eligible Employee shall automatically become a Participant in this Plan upon successful completion of the Waiting Period indicated on the first page of the SPD (not to exceed 90 days).

4.02 **Opt Out Allowed**. (Not applicable to the Qualified Small Employer HRA (QSEHRA)) An employee (or former employee) can permanently opt out and waive future reimbursements from this HRA at least annually (and upon termination of employment). Upon opting out, the remaining amounts in this HRA will be forfeited.

4.03 **Notification to Employees.** The employer will communicate in writing to all Participants the terms and conditions of this HRA through a Summary Plan Description, the Summary of Benefits and

Coverage, as well as Enrollment Materials.

4.04 **Termination of Participation**. A Participant will automatically cease to be an HRA Participant on the day of, or the end of the month in which the following events occur:

(a) Your death,
(b) The HRA terminates,
(c) You are no longer an Employee,
(d) The sponsor determines you made fraudulent or improper use of a plan, certificate or identification,
(e) For HRA plans that require enrollment in the Employers Group Health Plan and the Participant loses coverage under that Employers Group Health Plan, or
(f) The day you opt-out of coverage under this HRA Plan. You can opt-out of HRA coverage at each annual open enrollment; or if retiree benefits are provided under this HRA Plan, you can opt-out the day you terminate employment.

Upon termination a Participant can submit claims for coverage incurred prior to the termination date as long as they are submitted on or before the Run Out End Date.

4.05 **Continuation of Coverage (COBRA)**. This HRA is subject to the rules set forth by the Consolidated Omnibus Budget Reconciliation Act (COBRA), unless the Employer employed less than 20 employees on a typical business day during the preceding calendar year, or this Plan is a Qualified Small Employer HRA (QSEHRA).

4.06 **Employee Retirement Income Security Act (ERISA)**. This HRA is defined as a welfare benefit plan subject to ERISA. This can include but is not limited to the Summary Plan Description, Summary of Material Modification, IRS Form 5500, and Summary Annual Report.

4.07 **Terminated Employee**. Unless this HRA has a retiree benefit, a terminated employee's account will be capped to the balance of the account at the time of termination. Claims that are incurred prior to the date of termination can be submitted through this HRA's applicable Run Out End Date. The Run End Date for the current Plan Year is stated on the Summary Plan Description.

4.08 **Family Medical Leave Act.** The Family & Medical Leave Act of 1993 (29 U.S.C. 2611) as amended, is referred to as FMLA. FMLA Leave will not be available to Employees for Plan Years in which the Employer has fewer than 50 Employees as counted in that Act. For Plan Years in which the Employer has 50 or more Employees, the Employer is required to make FMLA Leave available to Eligible Employees under circumstances that are prescribed by applicable federal law, including a period in which an Employee is off due to the FMLA shall be treated in accordance with the rules for a layoff or a leave of absence and provided to the extent required by the FMLA (e.g., the employer will continue to pay its share of the contribution to the extent the Participant opts to continue coverage). If the Employer is subject to the FMLA, a Participant may revoke or continue an election through the plan upon commencement of the FMLA Leave, whether such leave is paid or unpaid. This provision applies in addition to any other right to revoke and reelect benefits under the plan. Upon return from FMLA Leave, a Participant may be reinstated to all pre-leave elections.

Article V: Election of Available Benefits

5.01 **Available Benefits**. This HRA will provide benefits for Eligible Medical Expenses incurred during the Plan Year for a Participant, and a Participant's Spouse or Dependents, if any. The Summary Plan Description will provide the Reimbursement Limits per Plan Year, as well as a detailed description of all limitations and exclusions. The benefits are not provided for any Eligible Medical Expense that has been submitted to and paid by any other source, unless laws related to the coordination of benefits require the reimbursement.

5.02 **Carryover**. If there is carryover of any unused benefit from one Plan Year to another, it will be indicated on the first page of the SPD, including the maximum amount that can be carried over. No cash outs are allowed. If an Employee's participation in the Plan ends, the period of coverage ends on the day of the terminating event. Any expenses incurred after that date are ineligible for reimbursement. If the Employee has not incurred Qualified Expenses equal to the amounts allocated on their behalf under this Plan before that date, the unused amount is forfeited to the Employer. All forfeited amounts become the property of the Employer. The Employer can use forfeited amounts for the payment of administrative expenses under this Plan, or to assign to future allocations that are not dependent on a Participants prior reimbursement experience.

5.03 **Forfeitures.** Any expenses incurred after the date a Participant terminates coverage under this HRA will not be reimbursed unless COBRA continuation coverage is elected and the COBRA premium is paid. Any claim not submitted by the end of the Run Out Period will not be covered. Any remaining amount in a Participant's account will be forfeited.

5.04 **Services Not Covered**. The following examples would usually not qualify as expenses eligible for reimbursement even though recommended by a doctor: Insurance premium for long term care plans that are not considered "qualified" by the IRS; fixed indemnity plan, fixed indemnity cancer policies, hospital indemnity insurance premium; expenses for cosmetic procedures or cosmetic items; items that are for the general wellbeing of a Participant; items that would have been purchased by a Participant even if the Participant did not have a medical condition such as a toothbrush; vacation and travel expenses even if for rehabilitation or prescribed by a doctor; and, long term care expenses that are not for actual medical care.

Article VI: Claims

6.01 **When to File**. Claims should be filed as soon as reasonably possible after an Eligible Medical Expense is incurred, and no later than the Run Out End Date.

6.02 **How to File**. All claim filed with the Plan must provide verification from a third party of the date of service, the amount of the service, and a description of the service that provides enough detail to determine whether the service is an Eligible Medical Expense. A claim can be submitted by methods allowed by the Plan including the use of a debit card meeting IRS requirements, a signed reimbursement form or online.

6.03 **Participant Certification**. The Plan requires Participants to certify that each expense submitted for reimbursement has actually been incurred and has not previously been reimbursed (i.e., there is no "double-dipping"), and reimbursement will not be sought from any other source, such as another health plan for medical tax advantaged account services and the card will only be used for legitimate eligible expenses, limited to persons eligible for reimbursement.

6.04 **Claim Review**. If a claim is denied in whole or in part, the Plan will send a written notice within 30 days after the date the claim was received. This time period may be extended for an additional 15 days for matters beyond the Plan's control, including in cases where a claim is incomplete. The Plan will provide written notice of any extension, including the reasons for the extension and the date by which a decision is expected. When a claim is incomplete, the extension notice will also specifically describe the required information needed. You will have 45 days from receipt of the notice in which to provide the specified information. The time for a decision on your claim will be suspended until the specified information is provided.

6.05 **Denial and Appeal Procedure**. A Participant or his/ her authorized representative can appeal a decision made to deny a claim by sending a written request for an appeal to the Plan within 60 days of the decision to deny the claim. The appeal will be performed in a manner that does not afford deference to the initial determination and will be conducted by the Employer or designee. A Participant can request, free of charge, reasonable access to, and copies of, all documents and records relevant to the decision. Benefit appeals for denied claims are addressed in the Qualified Benefits Plan descriptions provided by the Employer.

Article VII: Plan Termination

7.01 **Plan Termination**. The Plan or any portion of the Plan shall be subject to termination at any time by the Employer. Unclaimed funds shall become payable as the Plan Administrator may direct. Such direction may include, but is not limited to:

(a) a continuation of the Plan in order to pay balances for valid claims submitted, or

(b) a distribution of the Participant balances subject to the Plan.

7.02 **Employer Right to Terminate**. The employer may terminate the Plan at any time. In the event of a dissolution, merger consolidation, or re-organization of the employer, the Plan shall terminate unless the Plan is continued by a successor employer.

Article VIII – Excepted Benefit HRA (EBHRA)

8.01 **Purpose.** The Summary Plan Description (SPD) indicates whether this HRA is an EBHRA. All the terms and conditions stated in this Plan Document are applicable to this EBHRA unless specifically changed by this Article X. If indicated as an EBHRA on the SPD, the Employer intends this Plan to comply with Treasury Regulation Health Reimbursement Arrangements and Other Account-Based Group Health Plans (Fed Reg 28888). An EBHRA is not subject to health care reform's PHSA mandates or HIPAA's portability and nondiscrimination rules. An EBHRA is subject to HIPAA's administrative simplification requirements including the HIPAA privacy and security rules.

8.02 **Participant**. An eligible Employee shall automatically become a Participant in an EBHRA upon successful completion of the Waiting Period indicated on the first page of this SPD (not to exceed 90 days). An Eligible Employee must be eligible for other nonexcepted, non-account-based group health plan coverage sponsored by the Employer for the plan year. However, the Eligible Employee does not need to enroll in such coverage. The following persons are excluded from participating in this Plan and are not Eligible Employees:

(a) Employees not eligible for other employer sponsored nonexcepted, non-account-based group health plan coverage for the plan year.

(b) Employees offered and/or enrolled in an Individual Coverage Health Reimbursement Arrangement.

Article IX – Individual Coverage HRA (ICHRA)

9.01 **Purpose.** The Summary Plan Description (SPD) indicates whether this HRA is an ICHRA. If indicated as an ICHRA on the SPD, the Employer intends this Plan to be an ICHRA under the Treasury Regulation regarding Health Reimbursement Arrangements and Other Account-Based Group Health Plans (Fed Reg 28888), in compliance with Sections 105 and 106 of the Internal Revenue Code of 1986 (the "Code") and shall be interpreted to accomplish that objective. In accordance with the forgoing, the cost of benefits provided pursuant to this Plan are intended to be eligible for deduction by the Employer and exclusion from the Participant's gross income. This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and is a Group Health Plan as defined in ERISA. This Plan is subject to continuation rights, i.e. COBRA Continuation. This Plan is subject to the Public Health Service Act mandates included in the Affordable Care Act.

9.02 **Participant**. A Participant will automatically cease to be a Participant on the date on which the Participant no longer maintains ICHRA-compatible individual health insurance. Employees with group health coverage, including a spouse's group health plan, are not eligible. An Employee will be afforded a special enrollment period in which to obtain coverage when coming on to the ICHRA or changing plans on an annual basis.

9.03 **Compatible Individual Health Insurance**. A Participant must be enrolled in Individual Coverage HRA-compatible individual health insurance (or Medicare coverage) for each month the employee (or if applicable, the employee's family member) is covered by this Individual Coverage HRA. This can be individual health insurance including coverage purchased on an Exchange. This insurance cannot be coverage consisting solely of vision, dental, or similar "excepted benefits. An Employee may not enroll in the Individual Coverage HRA and only TRICARE without enrolling in an individual health insurance policy (or Medicare). The ICHRA compatible individual health insurance plan is not an employer sponsored group health plan, it is not subject to ERISA, and no continuation of coverage after termination is required under federal or state law.

9.04 **Written Acknowledgement**. A Participant must furnish a written acknowledgement to the Employer or its Service Provider that the Employee is covered under a compatible individual health insurance plan in a format provided by the Employer. The Plan becomes effective for a Participant on the day the first claim for premium is filed. A Participant must certify ongoing enrollment at the time of each premium payment requested from this Plan.

Article X – Qualified Small Employer HRA (QSEHRA)

10.01 **Purpose.** The Summary Plan Description (SPD) indicates whether this HRA is an QSEHRA. If indicated as an QSEHRA on the SPD, the Employer intends this Plan to be a QSEHRA under The Cures Act of 2016 and in compliance with Sections 105 and 106 of the Internal Revenue Code of 1986 (the "Code") and shall be interpreted to accomplish that objective. In accordance with the forgoing, the cost of benefits provided pursuant to this Plan are intended to be eligible for deduction by the Employer and exclusion from the Participant's gross income. This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), however it is not a Group Health Plan as defined in ERISA. This Plan is not subject to any continuation rights such as COBRA Continuation. This Plan is not subject to the Public Health Service Act mandates included in the Affordable Care Act.

10.02 **Participant**. An Eligible Employee shall automatically become a Participant in this Plan upon successful completion of the Waiting Period indicated on the first page of the SPD (not to exceed 90 days).
A Participant will automatically cease to be a Participant on the earliest of the following dates the date on which this Plan is terminated by the Employer The date on which the Participant's employment with Plan Sponsor is terminated, whether termination is initiated by the Participant or the Plan Sponsor.

Article XI – Spousal Incentive HRA (SIHRA)

11.01 **Purpose.** The Summary Plan Description (SPD) indicates whether this HRA is an SIHRA. If indicated as an SIHRA on the SPD, the Employer intends this Plan to be a SIHRA under the Treasury Regulation regarding Health Reimbursement Arrangements and Other Account-Based Group Health Plans (Fed Reg 28888), in compliance with Sections 105 and 106 of the Internal Revenue Code of 1986 (the "Code") and shall be interpreted to accomplish that objective. In accordance with the forgoing, the cost of benefits provided pursuant to this Plan are intended to be eligible for deduction by the Employer and exclusion from the Participant's gross income. This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and is a Group Health Plan as defined in ERISA. This Plan is subject to continuation rights, i.e. COBRA Continuation. This Plan is subject to the Public Health Service Act mandates included in the Affordable Care Act.

11.02 **Participant**. The Participant's spouse must be enrolled in compatible spousal employer-sponsored group health insurance for each month the Participant, the Participant's spouse and dependents (if applicable) are covered by this SIHRA. This spousal employer-sponsored health insurance cannot be coverage consisting solely of vision, dental, or similar excepted benefits. A Participant, their spouse and their dependents will automatically cease to be a Participant in the SIHRA on the date on which the Participant's spouse no longer maintains coverage for the Participant, the Participant's spouse or dependents.

11.03 **Written Acknowledgement.** A Participant must furnish a written acknowledgement to the Employer or its Service Provider that the Participant, the Participant's spouse and/or dependents (if applicable) are covered under the Participant's spouse's employer's nonexcepted, non-account based group health plan in a format provided by the Employer. The Plan becomes effective for a Participant on the day the Participant, the Participant's spouse and/or dependents (if applicable) first become covered under the Participant's spouse's employer's group health plan. The Participant must certify ongoing enrollment in the spouse's employer's plan at the time of each reimbursement requested from the SIHRA.

Article XII Administration

12.01 **Employer's Duties.** In addition to any rights, duties or powers specified in this Plan Document, the Employer will have the following rights, duties, and powers:

- **(a)** to interpret the plan, to determine the amount, manner and time for payment of any benefits under the plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the plan;
- **(b)** to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the plan, and from time to time, amend or supplement such rules and regulations;
- **(c)** to determine the rights of any participant, Spouse, or Dependent to benefits under the Qualified Benefit Plans;
- **(d)** to develop appellate and review procedures for any Participant, Spouse, or Dependent denied benefits under the plan;

(e) to maintain records, it may require in connection with the proper administration of the plan;
(f) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the plan, provided that such allocation or delegation and the acceptance thereof is in writing;
(g) to correct any defect, supply any omission, or reconcile any inconsistency in the plan in such a manner and to such extent as it shall be deemed expedient to administer the plan;
(h) to amend or terminate this plan.

12.02 Information to be Provided to Employer. The Employer, or any of its agents, will collect employment records of Participants under the plan. These records will include any information the Employer may need for the proper administration of the plan. A Participant will furnish the Employer the data the Employer reasonably requests to ensure the proper and efficient administration of the plan.

12.03 Misstatements. Any misstatement or other mistake of fact will be corrected as soon as reasonably possible upon notification to the Employer and any adjustment or correction attributable to such misstatement or mistake of fact will be made by the Employer as he considers equitable and practicable.

12.04 Medical Child Support Orders. The Employer will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which complies with federal or applicable state law, including 29 USC Sec. 1169 relating to Qualified Medical Child Support Orders (QMCSO), including any federal regulations or state laws relating to the same. On the date coverage is provided as directed by a QMCSO the Employee-parent will become eligible to participate in this plan in order to pay his/her share of the cost of the coverage on a pre-tax basis.

12.05 The Privacy Rule. Protected Health Information ("PHI") is defined as information that is created or received by the Employer which relates to the past, present, or future physical or mental health or condition of a Participant; or, the provision of healthcare to a Participant; or the past, present, or future payment for the provision of healthcare to a Participant; and that identifies the Participant. The test is whether there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased.

(a) Access to PHI: The Employer's access to PHI is restricted to the minimum information necessary to administer the Healthcare FSA. This includes obtaining Participant elections and reimbursements for payroll administration. The Employer has access to PHI submitted for claims reimbursement when that claim is on an appeal from an adverse decision. Only the Benefits Coordinator and Employees trained in the federal privacy rule will have access to the PHI.

(b) Permitted and Required Uses and Disclosures of PHI by the Employer: The Employer may use and disclose PHI for plan administration functions only as permitted and required by this Plan Document, or as required by law. The Employer will not use or disclose PHI for employment-related actions or in connection with any other Employee benefits plan. When necessary, the Benefits Coordinator will disclose the PHI to consultants and experts as required by the Department of Labor for a full and fair review or to perform plan non-discrimination testing as required by law.

(c) Complaints: If a Participant has any complaints regarding the way in which the Employer has handled PHI said Participant may complain to the Benefits Coordinator. No response from the Benefits Coordinator is required. A copy of this complaint procedure shall be provided to the Participant upon request. The Benefits Coordinator will keep a copy of the complaint, applicable documentation, and disposition if any, for a period of 6 years from the end of the Plan Year in which the act occurred.

(d) No Retaliation: No Employee will intimidate, threaten, coerce, discriminate against, or take other retaliatory action against Participants for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under the federal Privacy Rule.

(e) Firewall: The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of the group health plan; and ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

Employer will do the following:

1) Ensure that any subcontractors or agents to receive PHI agree to the same restrictions described above,

2) report to the health plan any use or disclosure that is inconsistent with this Plan Document or the federal Privacy Rule,

3) make the PHI information accessible to the Participants,

4) allow Participants to amend their PHI,

5) provide an accounting of its disclosures of PHI as required by the Privacy Rule,

6) make its practices available to the Secretary of Health and Human Services for deter mining compliance, and

7) return and destroy all PHI when no longer needed, if feasible.

12.06 **The Federal Security Rule.** This rule is intended to bring the plan into compliance with the "HIPAA Security Rule" as published on February 20, 2003 by the United States Department of Health and Human Services (HHS), and amended, including the final Security Standards under the Health Insurance Portability and Accountability Act of 1996 and the HITECH Act (Health Information Technology for Economic and Clinical Health Act) of the 2009. The Electronic Media contemplated by the HIPAA Security Rule includes the following:

(a) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission. In order to send and receive Protected Health Information ("PHI" as defined in the Plan Document) necessary for plan administration by Electronic Media, the Employer will implement reasonable and appropriate safeguards for electronic PHI created, received, maintained or transmitted to or by the Employer on behalf of the group health plan; ensure that electronic "firewalls" are in place to secure the electronic PHI; ensure that all agents and subcontractors with access to electronic PHI comply with the security requirements; Report to the group health plan any security incident of which it becomes aware.

Article XIII: Plan Construction

13.01 **Taxation**. The Employer makes no commitment or guarantee that any amounts elected or paid for the benefit of a Participant 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.

13.02 **Uniform Exercise of Powers**. The Employer shall at all times act in good faith and in a non-discriminatory manner and shall follow a consistent policy on comparable issues. All employer actions and determinations shall be duly recorded and all such records, together with such other documents as may be necessary for the administration of this Plan shall be preserved. Employer decisions regarding any disputed questions relative to a Participant's rights hereunder and upon all matters within the scope of its authority shall be final and binding on all interested parties.

13.03 **Plan Discrimination and Recession**. This Plan does not discriminate for determining eligibility based on health status. medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, or any other health status-related factor determined appropriate by future applicable federal regulations. The does not discriminate in favor of highly compensated individuals as to eligibility, allocations and benefits, in accordance with applicable provisions of the Code. The Employer may take such actions as amending the Plan, excluding certain highly compensated Employees from participation in the Plan, if, in the Employer's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules. Employee participation in this Plan will not be rescinded for any reason except for instances when a Participant commits a fraudulent act or an intentional misrepresentation to the Plan, Plan Administrator, Plan Sponsor or other entity that is assigned to administer any term of the Plan.

13.04 **Construction**. No provision of this Plan shall be construed to conflict with any U.S. Treasury Department, Department of Labor, or Internal Revenue Service Regulation, Ruling, Release or

Proposed Regulation or other order which affect, or could affect the terms of the Plan. This Plan will be in compliance with any changes related to the Internal Revenue Code, ERISA, COBRA and Department of Labor.

13.05 **Entire Document**. This Plan Document, and the documents expressly incorporated by reference in this Plan Document, shall constitute the entire document and shall govern the rights, liabilities and obligations of the Plan, except as it may be modified in writing by the Employer.

13.06 **Severability**. In the event any provisions of this document shall be held illegal or invalid for any reason by law or a court of competent jurisdiction, said illegality or invalidity shall not affect the remaining provisions included herein either initially, or beyond the date said provisions are first held to be illegal or invalid, provided the basic purposes thereof can be affected through the remaining valid and/or illegal provisions.

13.07 **Non-Alienation**. No benefit payable at any time under this Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

13.08 **Rights Against the Employer**. Nothing in this Plan shall be construed as giving any Participant or third party any legal or equitable rights against the Employer, or as giving any person the right to be employed by the Employer.