HEALTH REIMBURSEMENT ARRANGEMENT

PLAN OF BENEFITS

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

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ARTICLE I. INTRODUCTION

Establishment of HRA Plan

The Employer has established the Employer Health Reimbursement Arrangement Plan (the "HRA Plan") as of the HRA Plan Effective Date shown in the Adoption Agreement. The HRA Plan is designed to provide certain eligible individuals certain health benefits as further described herein.

Legal Status

The HRA Plan is intended to qualify under Sections 105 and 106 of the Code, pursuant to IRS Notice 2002-45 addressing health reimbursement arrangements, and 29 C.F.R. § 2590.702-2 addressing health reimbursement arrangements that may be integrated with Individual Health Insurance Coverage and Medicare.

ARTICLE II. DEFINITIONS AND CONSTRUCTION

Definitions

The following words and phrases shall have the meanings indicated below, unless a different meaning is plainly required by the context:

"Account" means a Participant's separate bookkeeping account, maintained by the Employer in accordance with Article IV, that reflects the amount of Benefits available to or on behalf of the Participant and, if applicable, the Participant's Dependents, under the HRA Plan.

"Administrator" is the Employer, unless another person has been designated, and accepted such designation, in writing, as the "administrator" within the meaning of Section 3(16) of ERISA.

"Benefits" are the reimbursement benefits for Qualified Medical Expenses under the HRA Plan, as described in this Plan of Benefits.

"Claims Administrator" is Blue Cross and Blue Shield of South Carolina, or such other entity as the Administrator shall designate in writing.

"Claims Run-Out Period" means the time period specified in the Adoption Agreement, following the end of the Period of Coverage in which a Qualified Medical Expense was incurred, during which the expense must be submitted for reimbursement in accordance with the HRA Plan.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and codified in Section 4980B of the Code. Any reference to COBRA will be deemed to include any applicable regulations and sub-regulatory guidance pertaining to COBRA, and will also be deemed a reference to comparable provisions of future laws.

"Code" means the Internal Revenue Code of 1986, as amended. Any reference to any section of the Code will be deemed to include any applicable regulations and sub-regulatory guidance pertaining to such section, as well as any comparable provisions of future laws.

"Dependent" means the following individuals who are not offered a Traditional Group Health Plan by the Employer, and satisfy any additional requirements specified in the Adoption Agreement:

(a) Tax Dependents: A Participant's Spouse and any other person who is a Participant's dependent within the meaning of Section 152 of the Code, determined without regard to Subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and including any child of the Participant to whom Section 152(e) of the Code applies (such child will be treated as a dependent of both divorced parents).

(b) Adult Children: A non-tax-dependent child of a Participant, who has not attained the age specified in the Adoption Agreement. A "child" for this purpose means any individual who is a son, daughter, stepson, or stepdaughter of the Participant, a legally adopted individual of the Participant, an individual who is lawfully placed for legal adoption by the Participant, or an eligible foster child who is placed with the Participant by

an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

(c) Any other individual who must be provided Benefits under the HRA Plan in accordance with the applicable requirements of any QMCSO.

"Eligible Employee" is an Employee of the Employer who is not offered a Traditional Group Health Plan by the Employer, and satisfies any additional requirements specified in the Adoption Agreement. An individual entitled to receive coverage under the HRA Plan pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 is deemed an Eligible Employee.

"Employee" means any person employed by the Employer on the basis of an employer-employee relationship who receives remuneration for personal services rendered to the Employer, but excluding the following: (i) any leased employee within the meaning of Section 414(n)(2) of the Code; (ii) any person who has been classified by the Employer as an independent contractor and has had his compensation reported to the Internal Revenue Service on Form 1099, even if he has been reclassified as an "employee" (other than by the Employer), provided that if the Employer does reclassify such worker as an "Employee" for purposes of the HRA Plan, such reclassification shall only be prospective from the date the Employee is notified by the Employer of such reclassification; (iii) any employee who is included in a unit of employees covered by a collective bargaining agreement; (iv) any self-employed individual; (v) any partner in a partnership; and (vi) any person who owns more than 2% of the outstanding stock of a Subchapter S corporation, including a person deemed to own more than 2% by virtue of the ownership attribution rules under Section 318 of the Code.

"Employer" is the entity listed as the Employer, and any listed Related Employers authorized to participate in the HRA Plan (if applicable), in the Adoption Agreement, provided that only the Employer listed in the Adoption Agreement may amend or terminate the HRA Plan as described in Article VIII. For purposes of the preceding sentence, any "Related Employer" listed in the Adoption Agreement must be a member of a related group of organizations with the Employer, pursuant to Section 414(b), (c) or (m) of the Code.

"Entry Date" means the first day of the first Period of Coverage for which an Eligible Employee is eligible for and elects to participate in the HRA Plan, for himself and/or his Dependent(s), respectively.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended. Any reference to any section of ERISA will be deemed to include any applicable regulations and sub-regulatory guidance pertaining to such section, as well as any comparable provisions of future laws.

"Excepted Benefits" means the excepted benefits described in Section 9832(c) of the Code.

"Exchange" means a Health Benefit Exchange established pursuant to Subtitle D of Title I of the Patient Protection and Affordable Care Act, as amended, and 45 C.F.R. Parts 155 and 156.

"Health FSA" means a health flexible spending arrangement, as described in 26 C.F.R. § 1.125-5 (proposed), maintained by the Employer for its Employees.

"Highly Compensated Individual" means any Employee who at any time during the HRA Plan Year is a "Highly Compensated Individual" as defined in Section 105(h) of the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended. Any reference to HIPAA will be deemed to include any applicable regulations and sub-regulatory guidance pertaining to HIPAA, as well as any comparable provisions of future laws.

"HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, as amended. Any reference to any provision of the HITECH Act will be deemed to include any applicable regulations and sub-regulatory guidance pertaining to such section, as well as any comparable provisions of future laws.

"HRA Plan" means the HRA Plan described in this Plan of Benefits, as amended by the Employer from time to time.

"HRA Plan Effective Date" means the HRA Plan Effective Date listed in the Adoption Agreement.

"HRA Plan Year" means the twelve (12) month period listed in the Adoption Agreement.

"Individual Health Insurance Coverage" means individual health insurance coverage as defined in 29 C.F.R. § 2590.701-2, which does not consist solely of Excepted Benefits.

"Maximum Annual Amount" means the amount credited to each Participant's Account, for a Period of Coverage, to be available for reimbursement of Qualified Medical Expenses under the HRA Plan.

"Medicare" means coverage under Medicare Parts A and B or Part C, pursuant to Title XVIII of the Social Security Act, except that for purposes of the definition of Qualified Medical Expenses only, Medicare also includes Medicare Part D and Medicare supplemental (or "Medigap") insurance under Section 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1)).

"Member" means either a Participant or a Dependent who is participating in the HRA Plan, in accordance with Article III.

"Minimum Reimbursement Amount" means the minimum dollar amount that may be paid or reimbursed from the HRA Plan, as specified in the Adoption Agreement.

"Participant" means an Eligible Employee who is participating in the HRA Plan, in accordance with Article III.

"Period of Coverage" means the HRA Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate during an HRA Plan Year, the Period of Coverage means the portion of the HRA Plan Year following the date participation commences; and (b) for Employees who terminate participation during an HRA Plan Year, Period of Coverage means the portion of the HRA Plan Year prior to the date participation terminates.

"PHI" means "Protected Health Information" as defined in 45 C.F.R. § 160.103.

"QMCSO" means a qualified medical child support order, as defined in Section 609(a) of ERISA.

"Qualified Medical Expense" means an expense incurred by a Member for medical care, as defined in Section 213(d) of the Code, including premiums for Individual Health Insurance Coverage or Medicare. For purposes of the definition of Qualified Medical Expense only, "Medicare" includes Medicare Parts A, B, C, or D, and Medicare supplemental (or "Medigap") insurance under Section 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1)). Notwithstanding the foregoing, Qualified Medical Expenses include drugs or medicines only if such drugs or medicines are (1) available with a prescription only, (2) available without a prescription ("over-the-counter"), but the Member obtains a prescription for them, or (3) insulin.

To the extent that the HRA Plan provides for reimbursement of premiums for Individual Health Insurance Coverage, each Member may choose to enroll in, and obtain reimbursement subject to the same terms and conditions for, any Individual Health Insurance Coverage offered by any health insurance carrier available to the Member in the individual market.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law, and who is treated as the Participant's spouse under the Code.

"Traditional Group Health Plan" means any group health plan other than (a) an account-based group health plan, which includes but is not limited to a Health FSA or a health reimbursement arrangement described in Notice 2002-45, or (b) a group health plan that consists solely of Excepted Benefits.

ARTICLE III. PARTICIPATION

Eligibility to Participate

Each Eligible Employee and Dependent is eligible to participate in the HRA Plan, and such participation shall commence, on the later of his Entry Date or the HRA Plan Effective Date. On behalf of himself and any Dependent(s), and in a manner and form specified by the Administrator, each Eligible Employee shall have one

opportunity for each Period of Coverage, in advance of the first day of such Period of Coverage, to either (a) elect to participate in the HRA Plan, or (b) opt out and waive all future reimbursements of Qualified Medical Expenses under the HRA Plan.

The Employer has the sole and complete discretion to classify and determine which individuals are Eligible Employees and Dependents under the HRA Plan. In the event the classification of an individual who is excluded from eligibility is determined to be erroneous or is retroactively revised, the individual will nonetheless be excluded from eligibility for all periods prior to the date the classification is determined to be erroneous or is revised and will continue to be excluded from eligibility for future periods, unless otherwise determined by the Employer.

Initial Substantiation of Individual Health Insurance Coverage or Medicare

In order to become a Participant in the HRA Plan and receive reimbursement of premiums for Individual Health Insurance Coverage or Medicare for a Period of Coverage, an Eligible Employee must first substantiate, in advance of such Period of Coverage, that the Eligible Employee and each Dependent for whom coverage is sought under the HRA Plan is or will be enrolled in Individual Health Insurance Coverage or Medicare for the Period of Coverage. Such substantiation for any new Dependent must be provided in advance of the date that coverage under the HRA Plan for the new Dependent begins; provided that, if the new Dependent's coverage under the HRA Plan will be effective retroactively, such substantiation may be provided within 30 days after the date that the new Dependent's coverage under the HRA Plan is elected, but in no event may the HRA Plan reimburse any Qualified Medical Expense for the new Dependent until such substantiation has been provided.

In order to substantiate enrollment in Individual Health Insurance Coverage or Medicare, as applicable, an Eligible Employee may provide either of the following:

(a) Documentation from the health insurance carrier, Exchange, or the U.S. Centers for Medicare and Medicaid Services, showing that the Eligible Employee and any Dependents, as applicable, are or will be enrolled in Individual Health Insurance Coverage or Medicare. Such documentation may include an insurance or Medicare identification card, explanation of benefits, or documentation from an Exchange showing that the individual completed the Exchange's application and plan selection process.

(b) An attestation by the Eligible Employee stating that the Eligible Employee and any Dependent(s) are or will be enrolled in Individual Health Insurance Coverage or Medicare, the date that such coverage began or will begin, and the name of the insurance carrier or other provider of the coverage.

Ongoing Substantiation of Individual Health Insurance Coverage or Medicare

Following a Participant's initial substantiation of enrollment in Individual Health Insurance Coverage or Medicare for a Period of Coverage, no subsequent requests for reimbursement of Qualified Medical Expenses for the same Period of Coverage will be paid unless the Participant first substantiates, in a form and manner designated by the Administrator, that the Member on whose behalf the reimbursement of Qualified Medical Expenses is requested to be reimbursed continues to be enrolled in Individual Health Insurance Coverage or Medicare for the period in which the Qualified Medical Expenses were incurred.

Termination of Participation

Except as provided in Article V, a Participant or Dependent will cease to be a Member in the HRA Plan upon the earlier of:

(a) The termination or amendment of the HRA Plan such that the Participant or Dependent is no longer eligible to participate in the HRA Plan; or

(b) the date the Participant ceases (because of retirement, termination of employment, layoff, reduction in hours, loss of HRA Plan coverage, death, or any other reason) to be an Eligible Employee under the HRA Plan.

Reimbursements from an Account after termination of a Participant's or Dependent's participation will be made pursuant to Article V.

Notwithstanding anything herein to the contrary, if a Participant goes on a qualifying unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA") or the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), to the extent required by the FMLA or USERRA, the Employer will continue to maintain the Participant's existing coverage under the HRA Plan on the same terms and conditions as though he were still an active Employee.

ARTICLE IV. HRA ACCOUNT

Establishment of Account

The Employer will establish and maintain an Account with respect to each Participant, but will not create a separate fund or otherwise segregate assets for this purpose. The Account will merely be a recordkeeping account for the purpose of tracking credits, debits, and available reimbursement amounts under the HRA Plan.

Crediting of Account

The Employer shall determine in its sole discretion, and the Administrator shall communicate to Members in a manner that it deems appropriate (such as the HRA Plan's summary plan description), the Maximum Annual Amount credited to each Participant's Account to be available for reimbursement of Qualified Medical Expenses for the Period of Coverage. The Employer may change the amount so credited to each Participant's Account at any time. The Employer may, in its sole discretion, limit or treat as taxable compensation the amounts available for reimbursement to Highly Compensated Individuals, in compliance with section 105(h) of the Code.

A Participant's Account will be credited at the time(s) specified in the Adoption Agreement. To the extent that the Employer has elected in the Adoption Agreement to carry over a Participant's unused Account balance at the end of each HRA Plan Year, the amount credited to the Participant's Account will be increased by any such carryover, as described further below.

Debiting of Account

A Participant's Account will be debited during each Period of Coverage, or the Claims Run-Out Period, if applicable, for any approved claims for reimbursement of Qualified Medical Expenses incurred during the Period of Coverage.

HRA Funding Availability

The amount available for reimbursement of Qualified Medical Expenses is the amount credited to the Participant's Account under "Crediting of Account," above, reduced by any prior reimbursements debited under "Debiting of Account," above.

Funds for the reimbursement of Qualified Medical Expenses under the HRA Plan shall be disbursed to Members on a "first-come-first-served" basis; specifically, claims will be processed in the order in which they are filed and shall at all times be contingent upon the availability of funds credited to the Participant's Account.

HRA Carryovers

If any balance remains in a Participant's Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, and the Employer has elected in the Adoption Agreement to carry over a Participant's unused Account balance at the end of each HRA Plan Year, such balance shall be carried over to the next subsequent Period of Coverage, to the extent specified in the Adoption Agreement. Any additional remaining unused balance, if applicable, will be forfeited permanently to the Employer.

Upon termination of participation in the HRA Plan, coverage for the Participant and any Dependent(s) under the HRA Plan will cease, and expenses incurred after such time will not be reimbursed unless COBRA is elected and maintained as provided in Article V. In addition, any unclaimed reimbursement payments (*e.g.*, uncashed reimbursement checks) by the close of the HRA Plan Year following the Period of Coverage in which the corresponding Qualified Medical Expense was incurred shall be forfeited permanently to the Employer.

Additional Debit Card Fees

Fees may be charged for any additional debit cards issued to a Member.

ARTICLE V. REIMBURSEMENT

Reimbursement Amount

(a) *Maximum Reimbursement Amount.* The maximum amount that a Member may receive under the HRA Plan in the form of reimbursement for Qualified Medical Expenses is the balance currently available in the Participant's Account.

(b) *Limited to Expenses Incurred while Participating*. The HRA Plan reimburses a Member's Qualified Medical Expenses incurred during such Member's Period of Coverage only. A Qualified Medical Expense is incurred (1) when the medical care or service giving rise to the expense is furnished, or (2) in the case of premiums for Individual Health Insurance Coverage or Medicare, for any full calendar month of coverage to which such premium applies. Qualified Medical Expenses incurred before a Participant first begins participating in the HRA Plan or after a Participant ceases participating in the HRA Plan are not eligible for reimbursement.

(c) *Limited to Expenses not Reimbursable Under Other Source*. Qualified Medical Expenses will not be eligible for reimbursement under the HRA Plan to the extent that such expenses are reimbursable or have been reimbursed to or on behalf of the Member from any other source, including but not limited to any other accident or health plan or insurance coverage. If only a portion of a Qualified Medical Expense is reimbursable or has been reimbursed from another source, the Account can be used to reimburse the remaining portion of such Qualified Medical Expense if the requirements set forth in this Plan of Benefits are otherwise satisfied.

If a Member receives a reimbursement for a Qualified Medical Expense under both the HRA Plan and another source, the Member must refund the duplicate reimbursement amount to the HRA Plan in a manner designated by the Employer. In addition, if the HRA Plan makes an erroneous or excess payment to any Member, the Employer or its designee will be entitled to recover such excess amount from the Participant and/or Dependent, as applicable. The recovery of such overpayment may also be made by offsetting the amount of the overpayment against any other amount(s) payable from the HRA Plan to the Participant and/or Dependent, as applicable.

Notwithstanding the foregoing, the HRA Plan shall comply with the Medicare Secondary Payer provisions under Section 1862(b) of the Social Security Act (42 U.S.C. § 1395y(b)), to the extent applicable.

(d) *Reimbursement with a Flexible Spending Account.* Without limiting the forgoing paragraph, if a Member's Qualified Medical Expense is covered by both the HRA Plan and a Health FSA sponsored by the Employer, then reimbursement as between the HRA Plan and Health FSA must occur in the order specified in the Adoption Agreement.

Reimbursements After Termination of Eligible Employee Status

(a) *General*. Except as otherwise provided in this Article V, an individual's ability to receive Benefits under the HRA Plan will terminate when the individual ceases to be a Member, and the individual will not be eligible for reimbursements of Qualified Medical Expenses incurred after such date. Without limiting the foregoing, upon a Participant's termination of employment with the Employer, and following the claims Run-Out Period for Qualified Medical Expenses incurred prior to such termination of employment, all amounts remaining in the Participant's Account will be forfeited permanently to the Employer, unless and to the extent that coverage under the HRA Plan is continued through COBRA as described herein.

(b) *Post-Termination Reimbursements.* A former Member (or the former Member's estate) may obtain reimbursement for any of the Member's Qualified Medical Expenses incurred during a Period of Coverage prior to termination of participation, provided that the former Member (or estate, as applicable) submits a claim before the end of the applicable Claims Run-Out Period.

(c) *COBRA.*

i. *General.* To the extent required by federal law, Members whose HRA coverage terminates because of a COBRA "Qualifying Event," as that term is defined for purposes of Section 4980B(f)(3) of the Code, will be given the opportunity to continue (on a self-pay basis) the same coverage they had under the HRA Plan on the day before the Qualifying Event, for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). Such Members who elect COBRA coverage are referred to as "COBRA Members" for purposes of this Plan of Benefits. In the event that HRA Plan coverage is modified for all similarly situated non-COBRA Members, such COBRA Members shall be eligible to continue the same modified coverage that is provided to those similarly-situated non-COBRA Members.

ii. *HRA Plan Account for COBRA Members*. The Employer shall maintain an Account for any COBRA Member, for so long as he remains a COBRA Member. The amount available for reimbursement under COBRA shall never exceed the amount in the COBRA Member's Account.

iii. *Premium*. A premium for COBRA continuation coverage under the HRA Plan shall be charged to COBRA Members in such amounts and shall be payable at such times as are established by the Administrator, in accordance with COBRA. A COBRA Member will be eligible for reimbursement of Qualified Medical Expenses incurred after he ceased being an Eligible Employee or Dependent only if and to the extent that the COBRA Member continues to make timely payment of the COBRA premium and otherwise meets all requirements to remain a COBRA Member under the HRA Plan and COBRA.

iv. A COBRA Member shall be treated as a Participant for all purposes under this Plan of Benefits, unless stated otherwise.

(c) *Claims Run-Out for Termination of a Member.* The Claims Run-Out Period for a former Member shall run concurrently with COBRA, if applicable.

(a) *Termination of HRA Plan*. If the Employer terminates the HRA Plan, no person will have any right to reimbursements from the HRA Plan or any Account thereunder. All reimbursements not yet made before such HRA Plan termination will be void, and there will be no Claims Run-Out Period.

ARTICLE VI. CLAIMS AND APPEALS PROCEDURE

Definitions

The following definitions apply to this Article VI describing the claims submission, review, and appeal process.

(a) "Adverse Benefit Determination" means a denial of reimbursement under the HRA Plan, in whole or in part, and any retroactive termination of participation under the HRA Plan that constitutes a rescission of coverage under 29 C.F.R. § 2590.715-2712.

(b) "Final Internal Adverse Benefit Determination" means an adverse benefit determination that has been upheld by the Claims Administrator at the completion of the internal appeals process.

Initial Claims

A Participant or the Participant's authorized representative may submit a claim for reimbursement of Qualified Medical Expenses, in writing, in a form and manner prescribed by the Claims Administrator. Such a claim must be submitted by no later than the end of the Claims Run-Out Period for the Period of Coverage, and must include the following information:

(a) The person or persons on whose behalf the Qualified Medical Expenses were incurred;

(b) The nature and date of the Qualified Medical Expenses so incurred;

(c) The amount of the requested reimbursement;

(d) A statement that such Qualified Medical Expenses have not otherwise been reimbursed and are not reimbursable through any other source;

(e) Any bills, invoices or other statements from one or more independent third parties showing that the Qualified Medical Expenses have been incurred, and their amounts, together with any additional documentation that the Claims Administrator may request; and

(f) Any further substantiation as the Claims Administrator may require, including evidence of the Member's enrollment in Individual Health Insurance Coverage or Medicare, for the period for which the Participant requests reimbursement of premiums for such coverage, if applicable, as described in Article III.

The Claims Administrator will notify the Participant of its determination on a claim within a reasonable period of time, but no later than 30 days after receipt of the claim, unless the Claims Administrator notifies the Member that an extension of up to 15 days is necessary due to circumstances beyond the Claims Administrator's control. If the reason for the extension is that the Claims Administrator does not have enough information to decide the claim, the notice will describe the required information, and the Member will have at least 45 days from the date the notice is received to provide such information.

Timing and Method of Reimbursement

As soon as administratively feasible, but no more often than once per day after a submitted claim is approved by the Claims Administrator, the Employer (through the Claims Administrator) will pay or reimburse the Qualified Medical Expense, up to the amount of reimbursement approved, or if less, the unused amount remaining in the Participant's Account at that time. In no event shall any Benefits be provided under the HRA Plan in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Qualified Medical Expenses.

The HRA Plan may make payments or reimbursements of premiums for Individual Health Insurance Coverage or Medicare, as applicable, directly to the health insurance carrier or other entity accepting premiums for the coverage, if and to the extent provided in the Adoption Agreement. In all cases where the Participant has already paid the Qualified Medical Expense, the HRA Plan will disburse the reimbursement funds to the Participant only. If the Participant has not already paid the Qualified Medical Expense, and the HRA Plan disburses the reimbursement funds to the Participant, the Participant must use all such funds to pay the Qualified Medical Expense. It is the Participant's responsibility to utilize all HRA Plan reimbursements properly.

In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to payment or reimbursement under the HRA Plan, any such payment due may be made to the legal representative making the claim therefor, and such payment so made shall be in complete discharge of the HRA Plan's liabilities therefor and the obligations of the Claims Administrator and Employer.

If a Minimum Reimbursement Amount is indicated in the Adoption Agreement, the HRA Plan will not issue reimbursements of less than the Minimum Reimbursement Amount, with the exception of (1) the reimbursement of all remaining funds in the Participant's Account, or (2) the final claim for reimbursement processed after the Participant's termination of participation in the HRA Plan or, if applicable, at the end of the Participant's COBRA period or Claims Run-Out Period. Otherwise, if a reimbursement would be less than the Minimum Reimbursement Amount, the Employer will hold such reimbursement until such time as the total reimbursements requested by a Participant equal or exceed the Minimum Reimbursement Amount.

Contents of Initial Claim Denial Notices

If the Participant's initial claim is denied, in whole or in part, the Claims Administrator will furnish the Participant with a written notice of Adverse Benefit Determination setting forth:

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

(b) Reference to the specific HRA Plan provision on which the denial is based;

(c) A description of any additional material or information necessary for the Participant to complete his claim and an explanation of why such material or information is necessary;

(d) A description of the HRA Plan's review procedures and the time limits applicable to those procedures, including information regarding how to initiate an appeal and a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following an adverse determination on review;

(e) If an internal rule or guideline was applied in making the determination, an explanation of the rule or a statement that the rule will be provided free of charge upon request; and

(f) If the determination is based on a medical necessity or experimental exclusion, an explanation of the scientific or clinical judgment applied to make the determination or a statement that the explanation will be provided free of charge upon request.

Appealing Denied Claims

If a Participant's initial claim is denied in whole or in part, he may appeal to the Claims Administrator for a review of the denied claim. The appeal must be made in writing within 180 days of the Claims Administrator's initial notice of Adverse Benefit Determination, or else the Participant will permanently lose the right to appeal the denial. If the Participant does not appeal on time, he will also lose his right to file suit in court, as he will have failed to exhaust his internal administrative appeal rights under the HRA Plan.

A Participant's written appeal should state the reasons the Participant feels the claim should not have been denied, and include all additional facts and/or documents in support of the Participant's claim. The Participant will be provided, upon request and free of charge, all documents and other information relevant to his appeal. The Claims Administrator will review all written comments, documents, and information submitted with the Participant's appeal.

Review of Internal Appeal

The Claims Administrator will review and decide the Participant's appeal within a reasonable time not longer than 30 days after it is submitted, and will notify the Participant of its decision in writing. The Claims Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the appeal, except that any medical expert consulted in connection with the appeal will be different from any expert consulted in connection with the initial claim. The identity of any medical expert consulted in connection with the Participant's appeal will be provided.

The Claims Administrator will provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claims Administrator in connection with the appeal. In addition, before the Claims Administrator issues an adverse benefit determination on review based on a new or additional rationale, the Participant will be provided, free of charge, with the rationale. Information described in this paragraph will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is provided to give the Participant a reasonable opportunity to respond prior to that date.

Contents of Notice of Decision on Internal Appeal

If the decision on appeal affirms the initial Adverse Benefit Determination, the Participant will be furnished with a notice of Adverse Benefit Determination on review setting forth:

(a) Information sufficient to identify the claim;

(b) The specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description will include a discussion of the decision;

(c) Reference to the specific HRA Plan provision(s) on which the decision is based;

(d) A statement of the Participant's right to receive (on request and free of charge) reasonable access to and copies of all relevant documents and information;

(e) If the Claims Administrator relied on an internal rule, guideline, protocol, or other similar criterion in making the decision, either a description of that 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 thereof will be provided free of charge to the Participant upon request;

(f) A statement describing available internal appeals and external review processes, including information regarding how to initiate a second internal appeal (if the HRA Plan provides for a second internal appeal, as indicated in the Adoption Agreement), and a statement describing the Participant's right to obtain information about such procedures;

(g) a statement of the Participant's right to bring suit under ERISA Section 502(a); and

(h) The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 to assist individuals with the internal claims and appeals and external review processes.

Making a Second Internal Appeal

This section applies only if the HRA Plan provides for second internal appeals, as indicated in the Adoption Agreement. A Participant must pursue and exhaust a second internal appeal before pursuing an external review or filing a lawsuit. If a Participant's first appeal is denied, in whole or in part, and the Participant wants to appeal further, the Participant will have 60 days from receipt of the notification of the Adverse Benefit Determination on review to appeal in writing to the Claims Administrator.

The Participant's second internal appeal must outline the issues and may include additional supporting information and documents submitted by the Participant. The provisions described above with respect to appealing an adverse benefit determination on review will also apply to second internal appeals.

External Review

An external review will be available to the extent required by federal law and as described in this section. The provisions of this section will not be interpreted to extend coverage beyond such requirements under federal law nor to provide lesser rights than required under federal law.

If a Participant's coverage under the HRA Plan is rescinded, in accordance with 29 C.F.R. § 2590.715-2712, or if any form of medical judgement is used in issuing an Adverse Benefit Determination, and the Participant exhausts the internal claims and appeals process and receives a Final Internal Adverse Benefit Determination upholding the decision, the Participant may request an external review. An external review is a review by an independent review organization ("IRO") accredited by a nationally recognized private accrediting organization.

No other Adverse Benefit Determination under the HRA Plan, including based on a Member's failure to meet the requirements for eligibility under the HRA Plan, is within the scope of the external review process described herein. A Participant must exhaust the internal appeals process described in this Article VI in order to be eligible to request an external review.

A request for external review must filed within four (4) months after the date of receipt of the notice of Final Internal Adverse Benefit Determination (or the first day of the fifth month after the date of receipt of such notice if there is no corresponding date four months after such date (*e.g.*, March 1 if the notice of Final Internal Adverse Benefit Determination was received on October 30)).

Within five (5) business days following receipt of a request for external review, the Claims Administrator will conduct a preliminary review of the request to determine whether:

(a) The Member is or was covered under the HRA Plan at the time the Qualified Medical Expense was incurred;

(b) The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the Member's failure to meet the requirements for eligibility under the terms of the HRA Plan;

(c) The Member has exhausted the HRA Plan's internal appeal process, unless such exhaustion is not required under applicable law; and

(d) The Member has provided all the information and forms required to process an external review.

The Claims Administrator will issue a notification in writing to the Participant within one business day after completion of the preliminary review. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility. If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Claims Administrator will allow the Participant to perfect the request for external review within the later of (1) 48 hours after receipt of the notification, or (2) the end of the four-month period for filing the request for external review.

Upon a determination that a request is eligible for external review following the preliminary review, the Claims Administrator will assign an IRO accredited by a nationally recognized private accrediting organization. The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support a denial of Benefits. The IRO will notify the Participant in writing of the request's eligibility and acceptance for external review, and that the Participant may submit in writing within ten (10) business days following receipt of the notice any additional information that the IRO will consider when conducting the external review.

The IRO will review the claim *de novo* based on all evidence the IRO deems appropriate, and issue a final benefit determination to the Participant within 45 calendar days after receipt of the Participant's request for external review. Notices will be provided upon request in a non-English language as needed. Notices will include the following information:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under applicable law to either the HRA Plan or to the Participant;

(f) A statement that judicial review may be available to the Participant; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793.

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the HRA Plan immediately will provide payment for the claim.

When standard timeframes would seriously jeopardize the life or health of a Member or jeopardize the Member's ability to regain maximum function, an expedited review can be requested. An expedited review requires the HRA Plan to determine immediately if the request is complete and eligible for external review. Documents and information must be submitted to the IRO electronically, by telephone or facsimile, or any other expeditious method. The notice of final external review decision will be completed as expeditiously as circumstances require, but no more than 72 hours after the IRO receives the request for external review. If the notice of final external review decision is not in writing, within 48 hours after providing that notice the IRO will provide written confirmation of the decision to the Participant.

Exhaustion of Internal Claims and Appeals Processes

A Participant must exhaust all internal claims and appeals processes applicable to a claim, as described in this Article VI, before pursuing external review. No lawsuit may be brought with respect to HRA Plan Benefits until the administrative procedures described in this Article VI have been exhausted, including external review where applicable. All issues must be raised at each level of the claims and appeals process described in this Article VI,

or else they will be forever waived. Under no circumstances may any lawsuit be brought more than 180 days following issuance of the Final Internal Adverse Benefit Determination.

All claims and appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. An appeals decision will not afford deference to the initial Adverse Benefit Determination and will not be conducted by the individual who made the initial determination or his or her subordinate. The review will take into account comments, documents, records, and other information submitted, regardless of whether the information was previously considered on initial review. In making a claims determination, the Claims Administrator is required to interpret HRA Plan provisions in good faith in the best interest of Participants and Members, and is prohibited from taking into account either the amount of Benefits that will be paid to a Participant or the financial impact on the Employer.

ARTICLE VII. RECORDKEEPING AND ADMINISTRATION

Powers of Administrator

Benefits will be paid under the HRA Plan only if the Administrator determines, in its sole discretion, that the Participant is entitled to them. Without limiting the generality of the foregoing, the Administrator shall have the sole and absolute discretionary authority to perform its duties to administer the HRA Plan, and shall have all powers as it deems necessary or appropriate in its discretion to discharge its duties hereunder, including, but not limited to, the following exclusive authorities, powers, and discretion:

(a) To interpret the HRA Plan and to decide all questions arising in the administration (including all questions of eligibility, participation, and determination of amount, time and manner of payments of Benefits), construction, interpretation and application of the HRA Plan;

(b) To make such rules and guidelines as it deems necessary to carry out the provisions of the HRA Plan;

(c) To prescribe procedures to be followed and forms to be used by Participants to submit claims and appeals under the HRA Plan;

(d) To request and receive from Members such information as the Administrator shall from time to time determine to be necessary for the proper administration of the HRA Plan;

(e) To furnish Members with such reports with respect to the administration of the HRA Plan as the Administrator determines to be reasonable and appropriate;

(f) To receive, review, and maintain on file such reports and information concerning Benefits covered by the HRA Plan as the Administrator determines to be necessary and proper;

(g) To delegate any part of its responsibilities under the HRA Plan to such person or persons as it may deem advisable, and in the same manner revoke any such delegation of responsibilities;

(h) To review and override, in its sole discretion, any claims or internal appeals decisions issued by the Claims Administrator;

(i) To prepare and distribute information explaining the HRA Plan, and the Benefits under the HRA Plan, in such manner as it deems appropriate and in compliance with applicable law;

(j) To request and receive from all Members such information as it may from time to time determine to be necessary for the proper administration of the HRA Plan;

(k) To prepare and keep on file such reports and information concerning the Benefits covered by the HRA Plan as it determines from time to time to be necessary and proper;

(l) To appoint and employ such individuals or entities to assist in the administration of the HRA Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(m) To sign documents, or to designate an individual or individuals to sign documents, for the purposes of administering the HRA Plan; and

(n) To maintain the books of accounts, records, and other data in the manner necessary for proper administration of the HRA Plan and to meet any applicable disclosure and reporting requirements.

All decisions made by the Administrator in connection with the HRA Plan will be conclusive and binding on all persons, including Members.

HIPAA Compliance

Capitalized terms used but not otherwise defined in this section shall have the same meaning as those terms in the "HIPAA Privacy Rule" (45 C.F.R. Parts 160 and 164, as amended), and the "HIPAA Security Rule" (45 C.F.R. Parts 160, 162 and 164, as amended) (jointly the "HIPAA Rules"). References to specific regulatory sections refer to the applicable sections of the HIPAA Rules as are currently in effect and any successor provisions of similar import.

(a) The HRA Plan may use or disclose PHI only to the extent required or permitted under the HIPAA Privacy Rule.

(b) The HRA Plan will disclose PHI (other than Summary Health Information) to the Employer only upon receipt of a certification that the provisions of this section ("HIPAA Compliance") have been incorporated into the HRA Plan documents, and the Employer agrees to comply with the provisions of this section. The Employer expressly makes such certification and agreement by executing the Adoption Agreement for this Plan of Benefits.

(c) The Employer will not disclose any PHI to its employees, agents, or other workforce members, except for plan administration functions that meet the definitions of "payment" or "health care operations" under 45 C.F.R. § 164.501, as such terms relate to the HRA Plan. For this purpose, "plan administration functions" do not include employment-related actions or decisions or activities in connection with any other benefit or employee benefit plan of the Employer. The HRA Plan's HIPAA privacy policies describe the employees, classes of employees, agents, or other workforce members who may have access to PHI. Such individuals will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Employer) for any use or disclosure of PHI in violation of, or noncompliance with, the provisions of this section. The Employer will promptly report any breach, violation, or non-compliance to the HRA Plan and will cooperate with the HRA Plan to correct the violation or noncompliance, impose appropriate disciplinary action and/or sanctions, and mitigate any deleterious effect of the violation or noncompliance.

(d) Neither the Employer nor Claims Administrator will use or further disclose PHI received in connection with the HRA Plan in a manner that would violate the requirements of the HIPAA Privacy Rule, including if the use or disclosure were done by the HRA Plan.

(e) The Employer and the Claims Administrator will ensure that any agents, including any and all subcontractors, to whom they provide PHI received from or in connection with the HRA Plan agree to the same restrictions and conditions that apply to the Employer and Claims Administrator, respectively, with regard to such PHI.

(f) The Employer will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Employer, unless and to the extent permitted under the HIPAA Privacy Rule.

(g) The Employer and the Claims Administrator will report, or ensure reporting is completed, to the HRA Plan any use or disclosure of PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for herein.

(h) The Employer and the Claims Administrator, as applicable, will provide access to PHI in a Designated Record Set, at the request of the HRA Plan, and in the time, manner, and place designated by the HRA Plan, to the HRA Plan; or, as directed by the HRA Plan, the Employer or Claims Administrator, as applicable, will provide such access to an Individual in order to meet the requirements of 45 C.F.R. § 164.524.

(i) The Employer and the Claims Administrator, as applicable, will make PHI in a Designated Record Set available to the HRA Plan in the time, manner, and place designated by the HRA Plan, to the extent required for amendment, and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526.

(j) The Employer and the Claims Administrator, as applicable, will make PHI and information related to its disclosures of PHI available to the HRA Plan in the time, manner, and place designated by the HRA Plan, to the extent required to provide an accounting of disclosures pursuant to an Individual's request, in accordance with 45 C.F.R. § 164.528. The Employer or Claims Administrator will document such disclosures of PHI and information related to such disclosures as would be required for the HRA Plan to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

(k) The Employer and the Claims Administrator will make their internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services, upon request, for purposes of determining the HRA Plan's compliance with the HIPAA Privacy Rule, unless a court of competent jurisdiction determines that this is not required under the HIPAA Privacy Rule.

(l) If feasible, the Employer and the Claims Administrator, as applicable, will return or destroy all PHI received from the HRA Plan that the Employer or Claims Administrator still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made (or 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);

(m) The Employer will ensure adequate separation between the Employer and the HRA Plan, as required by 45 C.F.R. § 164.504(f)(2)(iii). This adequate separation shall be further established as follows:

- The Employer will cause the HRA Plan to adopt policies and procedures regarding permissible PHI disclosures to the Employer for plan administration or other lawful purposes. Such policies and procedures will include requirements for using and for disclosing only the minimum necessary PHI;

- The Employer will restrict access to and use of PHI by its employees, agents, and other workforce members to the plan administration functions that the Employer performs for the HRA Plan;

- The Employer will comply with the requirements of the HITECH Act and its implementing regulations to provide notification to affected individuals, the Secretary of the U.S. Department of Health and Human Services, and the media (when required) if the HRA Plan or one of its Business Associates discovers a Breach of Unsecured PHI; and

- The Employer will ensure that the adequate separation between the HRA Plan and the Employer, required by 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(n) The Employer and the Claims Administrator each will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the HRA Plan;

(o) The Employer and the Claims Administrator each will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and

(p) The Employer and the Claims Administrator each will report to the HRA Plan any Security Incident of which it becomes aware, including any successful unauthorized access, use, disclosure, modification, or destruction of electronic PHI or interference with systems operations in an information system containing electronic PHI.

The claims procedures described in Article VI shall be used to resolve any issues of HIPAA non-compliance with the HRA Plan.

ARTICLE VIII. GENERAL PROVISIONS

Funding the HRA Plan

All amounts payable under the HRA Plan shall be funded solely by the Employer, and paid exclusively from the Employer's general assets. The Employer has hired the Claims Administrator solely to administer the HRA Plan on its behalf, and the Employer remains at all times solely responsible for all payments under the HRA Plan. No Employee contributions are permitted under the HRA Plan. Under no circumstances will Accounts be funded with salary reduction contributions, flex credits, or otherwise under a cafeteria plan.

There is no trust or other fund from which Benefits are paid. Nothing herein shall be construed to require the Employer, or any other person or entity, to maintain any trust or other fund, or to segregate any amounts, from which reimbursements are to be paid under the HRA Plan. No Member 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 HRA Plan may be made. The Employer may, at any time or from time to time, alter the credits or dollars accumulated in an Account pursuant to the amendment process described herein.

No Contract of Employment

Nothing contained herein is intended to be or shall be interpreted as constituting or creating a contract of employment or other similar arrangement between any individual and the Employer, nor will the HRA Plan be considered an inducement for employment of any individual, or effect or modify the terms of an Employee's employment in any way. The HRA Plan shall not be deemed to give any individual the right to be retained in the service of the Employer nor interfere with the right of the Employer to discharge any Employee at any time regardless of the effect such discharge may have upon that individual as a Participant in the HRA Plan. Nothing in the HRA Plan will be deemed to give any person any legal or equitable right against the Employer, except as expressly provided herein or required by law.

Amendment and Termination

The HRA Plan has been established with the intent of being maintained for an indefinite period of time. However, the Employer may amend or terminate the HRA Plan and any such amendment or termination will automatically apply to the Employer, Employees, and Dependents. The Employer is the sole entity or person authorized to amend the HRA Plan or to delegate authority to amend the HRA Plan. No amounts will be reimbursable from the HRA Plan upon its termination. The Employer makes no promise, guarantee or contract as to future availability of an Account, and may eliminate balances in or amounts credited to an Account at any time.

No Guarantee of Tax Consequences

Neither the Claims Administrator, Administrator, nor Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Member under the HRA Plan will be excludable from the Member'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 or Dependent.

Non-Assignability of Rights

No portion of the HRA Plan or any Account thereunder shall be liable for any debt, liability, contract, engagement or tort of any Member, nor be subject to charge, anticipation, sale, assignment, transfer, encumbrance, pledge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor transferable by operation of law. A Member shall not assign any rights to receive any reimbursement under the HRA Plan, and any attempt to do so will not be recognized, unless and to the extent required by law.

HRA Plan Fiduciary

The Administrator is the named fiduciary of the HRA Plan. The Claims Administrator performs purely ministerial functions in administering the HRA Plan at the Employer's and Administrator's direction, has no discretionary authority with respect to the HRA Plan, and shall not be deemed a fiduciary of the HRA Plan under ERISA.

Severability

In the event any provision of this Plan of Benefits is held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan of Benefits, and such remaining provisions shall be fully severable and the HRA Plan shall, to the extent practicable, be interpreted and enforced as if the illegal or invalid provision had never been included therein.

Code and ERISA Compliance

The HRA Plan shall be construed, enforced, and administered, and its validity determined, in accordance with all applicable requirements and provisions of the Code, ERISA, and all regulations issued thereunder, including the requirements for a health reimbursement arrangement to be integrated with Individual Health Insurance Coverage and Medicare under 29 C.F.R. § 2590.702-2. In the event of any conflict between any part, clause, or provision of the HRA Plan and the Code and/or ERISA, the provisions of the Code and/or ERISA shall be deemed controlling, and any conflicting part, clause, or provision of the HRA Plan shall be deemed superseded to the extent of the conflict.

Captions and Construction

The captions contained in this Plan of Benefits are included solely as a matter of convenience and for reference, and in no way define, limit, enlarge, or describe the scope or intent of the HRA Plan nor in any way will affect the HRA Plan or the construction of any provision thereof.

Words used in this Plan of Benefits in the masculine or feminine gender shall also be construed as the feminine or masculine gender, respectively, where appropriate. Words used in this Plan of Benefits in the singular or plural shall also be construed as the plural or singular, respectively, where appropriate.

Inability to Locate Payee

If the Administrator or its designee is unable to make payment to any Member or other individual to whom a payment is due under the HRA Plan because it cannot ascertain the identity or whereabouts of such individual despite reasonable efforts, then such payment, and all subsequent payments otherwise due to such Member, shall be forfeited permanently to the Employer following a reasonable time, as determined in the Administrator's sole discretion, after the date that the payment first became due.

Mistake

In the event of a mistake as to a Member's eligibility or participation, the allocations made to a Participant's Account, or the amount paid or reimbursed (or to be paid or reimbursed) to or on behalf of a Member, the Administrator shall, to the extent that it deems administratively feasible and otherwise permissible under applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise made adjustments to, such amounts as will in the Administrator's judgment accord to such Member the credits to the Account or distributions to which the Member is properly entitled under the HRA Plan. Such actions by the Administrator may include, but are not limited to, withholding from compensation paid to an Employee by the Employer any amounts owed to the HRA Plan or the Employer.