STATE OF INDIANA- VEBA
HEALTH REIMBURSEMENT ARRANGEMENT "HRA" ACCOUNT PLAN

Post-separation Benefits Plan Document
Amended and Restated as of January 1, 2017

Post-separation Only Full 213(d) Expense Coverage
PV-PS (01-01-2017)

ARTICLE I.

Name, Documents & Definitions

1.1 Name. The name of the Plan shall be the State of Indiana Health Reimbursement Arrangement "HRA" Plan (the "Indiana HRA Plan"). This Plan document version sets forth the terms and conditions for reimbursement of qualified IRC 213(d) expenses incurred after a Participant is retired or separated from service from the Employer who made contributions to the Plan and is referred to as the "Post-separation Benefits Plan." The Indiana HRA Plan may include one or more HRA plans or forms of HRA coverage from time to time. When used herein, the terms "Plan" or "HRA Plan" or "Indiana HRA Plan" shall refer to this Post-separation Benefits Plan either individually or collectively with other plans or forms of plan coverage included with the Indiana HRA Plan as the context indicates or requires. It is intended that the Plan and Trust qualify as a Voluntary Employees' Beneficiary Association under Internal Revenue Code § 501(c)(9).

1.2 Plan Documents. The Indiana HRA Plan shall consist of one or more Plan document versions, the Trust Agreement, the Employer Adoption Agreement, and (as applied to a particular Participant) the individual Participant Enrollment File, collectively the "Plan Documents". This Plan document version, together with the Trust Agreement, the individual Participant Enrollment File, and the Employer Adoption Agreement set forth the terms and conditions and shall constitute the Plan documents for Indiana HRA Post-separation Benefits Plan. This Plan document is hereby amended and restated and replaces the prior Post-separation Only Plan document dated as of January 1, 2014, in its entirety.

1.3 Post-separation and Retiree Plan. This Plan is a post-separation and retiree plan only. This Plan coverage is intended for any Participant who is a former Employee of the Employer who made or is making contributions on behalf of the Participant (or his or her Dependents according to the terms and conditions of the Plan). At the time a Participant separates from service from the Employer who has made or will continue to make contributions on behalf of the Participant, the Participant will be covered under this Post-separation Benefits Plan. Benefits under this Plan shall be limited to expenses incurred by a Participant or Dependents only after the Participant has retired from employment or otherwise separated from service with the Employer that made contributions to this Plan for such Participant and has otherwise met all other conditions for eligibility to become and remain a Participant hereunder

and file claims for Benefits as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer. This Plan coverage is exempt from certain provisions of PPACA known as the Mandates as a plan that covers less than two current employees.

1.4 Election to Forfeit Right to Benefits for Premium Tax Credit Eligibility. To the extent any Claims-Eligible Participant under this Post-separation Benefits Plan retains a positive account balance in his or her Participant Account during any month, PPACA provides that such Participant Account will generally constitute minimum essential coverage, as defined under IRC § 5000A, and will therefore preclude the Participant from claiming or becoming entitled to an IRC § 36B premium tax credit during that month to purchase coverage from a marketplace exchange established in accordance with PPACA. In order to prevent the Participant Account from precluding eligibility for an IRC § 36B premium tax credit, a Claims-Eligible Participant under this Post-separation Benefits Plan may, at any time, elect to waive and forfeit the right to Benefits for any Qualified Health Care Expenses incurred on and after the date of such election to and excluding the date on which such election is revoked by the Participant.

1.5 Election of Limited HRA Coverage. In lieu of the election permitted under Section 1.4, in order to become potentially eligible for an IRC § 36B premium tax credit, a Claims-eligible Participant under this Plan may, at any time, elect Limited HRA Coverage, the terms and conditions of which are governed by the Limited HRA Plan document. Except as specifically (a) permitted by applicable law and (b) approved by the Administrator, any election under this Section 1.5 shall be effective on and after the date of such election to and excluding the date on which such election is revoked by the Participant

1.6 Definitions.

"Administrator" means the person or persons designated in writing by the Employer in the Employer Adoption Agreement to carry out the responsibilities of the Administrator. Some or all of the responsibilities of the Administrator may be carried out by one or more third parties (including a third-party administrator) engaged by the Administrator under separate contracts; provided that, such third-party relationships will not reduce the Administrator's rights and responsibilities under the Plan Documents.

"Adverse Benefits Determination" means any denial of a request for benefits or any rescission or termination of benefits, in each case in whole or in part, all as more specifically described in the Department of Labor regulations, specifically, 29 C.F.R. § 2560.503-7(m)(4).

"Benefits" refers to reimbursements for or payments of Qualified Health Care Expenses as described in Section 5.1, as such Benefits may be limited by elections of the Participant, the terms of the Plan, or applicable law.

"Claimant" has the meaning ascribed to such term in paragraph 6.4.1 hereof.

"Claims Eligibility Date" is the latest date on which both of the following have occurred: (1) the date on which a contribution has been received by the Trust for an eligible Participant and (2) the date such Participant has become Claims-Eligible as described in Section 2.2; provided that, payment by the Plan of Benefits shall be (i) subject to the Administrator having first received a completed Participant Enrollment File for the Participant and (ii) limited to the extent there is a positive account balance in such Participant Account. The Claims Eligibility Date for any Participant Account cannot be earlier than the Participant Eligibility Date.

"Claims-Eligible" with respect to any Participant means that such Participant has become eligible for Benefits as described in Section 2.2.

"Collective Bargaining Unit" means a group of public employees, employed by an Employer, banded together for collective bargaining purposes.

"Dependent" means the Participant's spouse, dependent, or any child (who as of the end of the taxable year has not attained age 27) as determined under IRC §105(b).

"Effective Date" for this Plan shall be October 1, 2003, notwithstanding that this Plan and the Plan Documents have been amended and restated and may be further amended and restated or replaced from time to time.

"Employee" means any individual that an Employer determines is a current or former employee of such Employer, as the terms of "employee" is defined by Treasury Regulation § 1.501(c)(9)-2(b), including any such person covered by a Collective Bargaining Unit agreement providing for coverage in the Plan.

"Employer" means, individually and collectively, any Indiana school corporation or other governmental employer, including any legally constituted agency, department, board, or commission of the State of Indiana, a county, an incorporated or unincorporated city, town, or municipality, educational institution, or any political subdivision of or in the State of Indiana, that (i) constitutes a governmental employer under state law, (ii) is sufficiently affiliated with the State of Indiana for purposes of IRC 501(c)(9), and (iii) pursuant to its Employer Adoption Agreement, has adopted the Plan and the Trust Agreement and, upon its initial contribution of funds into the Trust, has become a settlor of the Trust. An Employer described in the preceding sentence shall be permitted to adopt the Plan and the Trust only if (i) there is evidence that Plan benefits were the subject of good faith bargaining between the Employer and an Employee Representative, or (ii) after the Employer were to adopt the Plan, a majority of Employees of all Employers who have adopted the Plan would be in, or represented by, a Collective Bargaining Unit.

"Employer Account" refers to the account maintained with respect to any Employer to record its contributions which have not been allocated to Participant Accounts, and adjustments related thereto, and established for the purpose of providing benefits permitted under IRC §501(c)(9).

"Employer Adoption Agreement" means an Employer Adoption Agreement executed by an Employer and accepted by the Administrator, pursuant to which, among other things, an Employer establishes the Plan and makes certain elections regarding its Plan, as the same may be amended, restated, or replaced from time to time. The terms and provisions of the Employer Adoption Agreement, contributions and disbursements pursuant to such Agreement, and any changes to such Agreement, are all subject to the rules, policies and procedures set forth in this Plan document or otherwise established by the Administrator, as the same may be amended, restated, or replaced from time to time.

"Excepted Benefits" means Qualified Health Care Expenses that would not be considered "minimum essential coverage" under IRC §5000A(f)(3). Excepted Benefits shall include benefits described under Treasury Reg. §54.9831-1(c)(3)(iii) and (iv), including expenses and premiums for coverage for any of the following, or as otherwise permitted by law:

(a) Medical care expenses substantially all of which are for the treatment of the eye or the mouth (including any organ or structure within the mouth); and

(b) Qualified long-term care services or medical care expenses incurred based on cognitive impairment or loss of functional capacity that is expected to be chronic, subject to indexed annual limits.

"Group Health Plan" or "GHP" means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) and such term "group health plan" is defined under IRC §§ 9032(a) and 5000(b)(1) and Treasury Regulation §54.9831-1(a)(1).

"Final Internal Adverse Benefits Determination" means an Adverse Benefits Determination that has been upheld by the Administrator at the completion of the internal appeals procedures set forth in Section 6.4.2.

"Independent Review Organization (IRO)" means an entity that performs independent external review of Adverse Benefits Determinations and Final Internal Adverse Benefits Determinations under the external review procedures set forth in Section 6.4.3.

"IRC" means the Internal Revenue Code of 1986, as amended from time to time.

"IRS" means the Internal Revenue Service.

"Limited HRA Coverage" is coverage that limits Benefits for various purposes as required or permitted by applicable law, including, without limitation:

(i) Eligibility for contributions to a health savings account (HSA);

(ii) To coordinate benefits for purposes of HRA coverage reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA);

(iii) To prevent preclusion of eligibility for an IRC § 36B premium tax credit during any month to purchase coverage from a marketplace exchange established in accordance with PPACA;

(iv) Eligibility for limited coverage prior to separation for Participants with Post-separation Accounts; and

(v) Eligibility for limited coverage for Dependents who are not integrated with an employer-sponsored group health plan at the time a Qualified Health Care Expense is incurred.

Limited HRA Coverage will be limited to Excepted Benefits only for purposes described in clauses (iii)-(v), and in other cases required by law or to exempt Plan coverage from certain legal and regulatory mandates, including certain mandates under HIPAA, MMSEA, and/or PPACA. The terms and conditions for Limited HRA Coverage is governed by a separate Limited HRA Plan document.

"Mandates" means provisions of PPACA known as the mandates and found under sections 2701-2719A of the Public Health Service Act ("PHSA"); Section 9815 of the IRC (incorporating the PHSA provisions into the IRC); and Section 715 of ERISA (incorporating the PHSA provisions into ERISA).

"Participant" means a current or former Employee who has become a Participant as described in Article II, and whose status as a Participant remains active pursuant to Section 2.4 with respect to at least one Participant Account. However, such Participant shall only become Claims-Eligible as described in Section 2.2.

"Participant Account" refers to any account maintained with respect to a Participant to record his share of the contributions and adjustments relating thereto.

"Participant Eligibility Date" is the date on which a contribution has been received by the Trust for an Employee, and such Employee becomes a Participant. The Participant Eligibility Date for any Employee may not be earlier than the Plan Adoption Date; provided that, for Participants whose plan assets have been transferred by the Employer from another plan, the Participant Eligibility Date may coincide with the Participant's eligibility date under the prior plan, if designated in writing by the Employer.

"Participant Enrollment File" means the paper enrollment form, online enrollment information, or enrollment file provided by the Employer or a Participant with the information required by the Plan Administrator in order to enroll a Participant in the Plan.

"Plan Adoption Date" is the date specified as such by the Employer in the Employer Adoption Agreement, or if not specified therein, the date on which the Employer Adoption Agreement is accepted and executed by the Administrator.

"Plan Year" is the period from October 1, 2003 through December 31, 2003 and each twelve-month period ending December 31 thereafter.

"PPACA" means the Patient Protection and Affordable Care Act and all rules, regulations, and regulatory guidance applicable to the Plan promulgated thereunder, as the same shall be amended from time to time.

"Premium Reimbursements" means premium reimbursements for out-of-pocket, after-tax payments made to insurance companies, health maintenance organizations, health plans, preferred provider organizations, qualified long-term care insurers, any part of Medicare, or to the Employer for COBRA premium payments.

"Qualified Health Care Expenses" means medical care expenses defined by IRC § 213(d) and IRC § 106(f) (for years to which IRC § 106(f) applies).

"Re-employed" means, with respect to a Participant who has become Claims-Eligible upon retirement from employment or other separation from service from the Employer who last made contributions into such Participant's Participant Account, that such Participant has become re-employed with such Employer (whether or not such re-employment is on a full-time, part-time, or temporary basis) under circumstances that would constitute a traditional employment relationship under customary employment standards and policies. Whether or not a Participant is "Re-employed" for purposes of Claims-Eligibility shall be subject to applicable law and rules, policies and procedures of the Employer.

"Sponsor" means HRA Administrator, LLC, an Indiana limited liability company.

"Trust" refers to the Trust established as of October 1, 2003, as part of the Plan pursuant to the Trust Agreement.

"Trust Agreement" means the Third Amended and Restated Trust Agreement, dated as of January 1, 2014, and adopted by employers within the State of Indiana who utilize one or more of the State of Indiana Health Reimbursement Arrangement "HRA" Account Plan(s) and the administrative services of the Administrator, as the same has been amended and restated and may be further amended and restated from time to time.

"Trustee" refers to the trustee of the Trust.

1.7 Interpretation of Capitalized Terms. Capitalized terms used herein and not otherwise defined in this document, shall have the meanings ascribed to such terms in the other Plan documents. In the event there is a conflict in the definition ascribed to any term in two or more Plan documents, Plan forms, or other Plan materials, the definition ascribed to such term

within any particular document shall apply for interpretation of that document, and if not defined therein, the meaning that shall apply for interpretation of a document shall be determined by reference first to the Trust Agreement, second to the Plan Document, third to the applicable Employer Adoption Agreement, and last to the applicable Participant Enrollment File.

ARTICLE II.

Participation and Claims-Eligibility

2.1 Eligibility as a Participant. Subject to the limitations of this Article II, and subject to the eligibility provisions of applicable law:

2.1.1 An Employee for whom an Employer has made contributions to this Post-separation Benefits Plan becomes a Participant under the Plan on the Participant Eligibility Date, provided that, such Employee shall not be "Claims-Eligible" under this Plan except as provided in Section 2.2.1 or Section 2.2.2 hereof.

2.1.2 An Employee for whom an Employer has made contributions to the In-service Benefits Plan becomes covered as a Participant under this Post-separation Benefits Plan on the date such Employee retires or otherwise separates from service from that Employer.

2.2 Claims-Eligibility.

2.2.1 Depending on the Employer's Plan design or elections, a Participant described in Section 2.1.1 may become "Claims-Eligible" under this Post-separation Benefits Plan, and eligible for full Benefits under Article V, only upon the Participant's retirement from employment or other separation from service with the Employer and upon satisfaction of any other eligibility provisions of Employer policies and applicable collective bargaining agreements and the Employer Adoption Agreement or other Employer action or adoption procedure accepted by the Administrator.

2.2.2 Depending on the Employer's Plan design or elections, a Participant described in Section 2.1.1 may become "Claims-Eligible" under the Limited HRA Plan, and eligible only for reimbursement of Excepted Benefits on the Participant Eligibility Date. In such case, the Participant shall become Claims-Eligible under this Post-separation Benefits Plan for full Benefits under Article V, only upon the Participant's retirement from employment or other separation from service with the Employer and upon satisfaction of any other eligibility provisions of Employer policies and applicable collective bargaining agreements and the Employer Adoption Agreement or other Employer action or adoption procedure accepted by the Administrator.

2.2.3 A Participant described in Section 2.1.2 is "Claims-Eligible" based upon the claims-eligibility date for such Participant under the In-service Benefits Plan.

2.3 Rehire Restriction on Claims-Eligibility.

2.3.1 If, after a Participant becomes Claims-Eligible for full Benefits under this Post-separation Benefits Plan as described in Section 2.2.1 or Section 2.2.2, such Participant subsequently becomes Re-employed by the same Employer, then, during any period that the Participant is Re-employed, the Participant shall not be covered or eligible for Benefits under this Post-separation Benefits Plan, but shall be eligible for Benefits as follows:

2.3.1.1 To the extent there is a remaining balance attributable to contributions originally made to the In-service Benefits Plan by an Employer on behalf of the Participant who is covered under this Post-separation Benefits Plan pursuant to Section 2.1.2, the Participant shall be covered and eligible for Benefits under and according to the terms and conditions of the In-service Benefits Plan.

2.3.1.2 To the extent there is a remaining balance attributable to contributions originally made to this Post-separation Benefits Plan, then during the period of Re-employment the Participant shall be covered and eligible for Excepted Benefits under the Limited HRA Plan according to the terms and conditions of the Limited HRA Plan document.

2.4 Duration of Eligibility. Once a Participant becomes Claims-Eligible under the Plan, the Participant's active status with respect to any Participant Account shall exist for so long as there is a positive account balance in such Participant Account, and thereafter, for two (2) consecutive Plan Years during which such Participant Account remains exhausted ("Dormant Account Period"). If a Participant Account remains exhausted for two (2) complete and consecutive Plan Years, the Participant's active status with respect to such Account shall terminate on the first day of the Plan Year that commences immediately after such two (2) year period. A Participant who has lost his or her active status with respect to any Participant Account may subsequently become a Participant in the Plan and Claims-Eligible as prescribed in Sections 2.1 and 2.2. During any Dormant Account Period for any Participant Account a Participant may or may not receive statements or other plan communications with respect to such Participant Account but will remain Claims-Eligible.

2.5 Nondiscrimination. The Plan is intended to comply with all nondiscrimination laws applicable to eligibility under, contributions to, and benefits of, the Plan (including any such rules prescribed by IRC §§ 105(h) and 501(c)(9), if applicable).

ARTICLE III.

Funding or Allocation of Benefits

3.1 Contributions and Allocation of Assets. The Employer shall make one or more contributions to this Plan, or designate assets to be subject to the terms of this Plan, with respect to its eligible Employees pursuant to Collective Bargaining Unit agreements (if applicable), Employer policies, or other legal obligations of the Employer, and/or the terms of this Post-separation Benefits Plan document, the In-service Benefits Plan document, or the Limited HRA

plan document, as applicable. Contributions, transfers, or assets designated to be subject to the terms and conditions of this Post-separation Benefits Plan, shall be specifically allocated to the applicable Participant Account for the purpose of providing for payment of the benefits described hereinafter or maintained in an Employer Account, as directed by the Employer in the Employer Adoption Agreement. Contributions to the Plan may include amounts transferred from another welfare benefit plan maintained for the benefit of Employees, provided that no such transfer will be permitted based on the election or direction of any individual Employee or that would otherwise cause the Plan to be treated as other than a health reimbursement arrangement qualifying under IRC §§ 105 and 106. Except for any contributions that constitute COBRA continuation premiums paid by Employees, no individual Employee contributions or direct or indirect salary reduction contributions by individual Employees will be permitted. All deposits, transfers, and other contributions (including COBRA contributions from Participants, if any) shall be on terms acceptable to the Administrator and pursuant to rules, policies and procedures established by the Administrator.

3.2 Administration of Contributions. All contributions and other amounts transferred to the Plan shall be held in the Trust and invested, administered, and distributed in accordance with the terms of the Plan. The Administrator shall not be under any duty to inquire into the timeliness or correctness of the amounts contributed to the Trust. Neither the Administrator nor any person other than the Employer shall have any duty to determine the amount, or to enforce the payment, of contributions to the Plan, and, in connection therewith, the Employer agrees to indemnify and hold harmless the Trustee, the Administrator, and any other service providers engaged by the Administrator as provided in the Employer Adoption Agreement. No provision of this Plan shall be construed as requiring the Employer to make or continue to make contributions to the Plan or Trust. Nothing in this Plan shall entitle the Administrator or any Participant to inquire into or demand the right to inspect the books of the Employer.

3.3 Use of Plan and Trust Assets. Except as otherwise provided herein or in the Employer Adoption Agreement, the Trust assets shall be used exclusively to pay benefits under the Plan and to defray reasonable expenses of administering the Plan and Trust.

3.4 Limitation on Rights. Except as otherwise provided herein and in the Employer Adoption Agreement, no person shall have any rights with respect to Trust assets allocable to any Participant Account except the rights of Participants, Dependents, and any other persons entitled to receive Benefits under such Participant Account in accordance with the terms, and subject to the limitations of, the Plan, and no such person shall be considered to have any legal or equitable ownership interest in any assets of the Plan or Trust. The rights of a Participant, Dependent, or any other person entitled to receive benefits from a Participant Account, shall not be subject to assignment or alienation, either by voluntary or involuntary act of the person or by operation of law and shall not be subject to attachment, execution, garnishment, or any other legal or equitable process except to the extent required by law.

ARTICLE IV.

Accounts

4.1 Participant Accounts and Employer Accounts. Accounting records shall be maintained by the Administrator to reflect that portion of the Trust with respect to each Participant Account and with respect to each Employer Account (regarding its contributions which have not been allocated), and the contributions, income, losses, increases and decreases for expenses or benefit payments attributable to each such account.

4.2 Receipt and Allocation of Contributions. Contributions will be credited as received by the Trustee and are to be allocated as directed by the Administrator (based upon instructions from the Employer). If any portion of any Employer contribution is not allocable to a specific Participant Account or an Employer Account pursuant to instructions from the Employer, or if a Participant Enrollment File is not submitted for any amount allocated to a Participant Account, the Administrator will allocate such amount to a non-interest bearing account for unallocated funds until such time as a Participant Enrollment File is submitted or further instructions are received from the Employer, or the Administrator may return such contribution to the Employer.

4.3 Accounting Steps. In accordance with rules, policies, and procedures established by the Administrator, accounting steps shall:

4.3.1 Allocate and credit any Employer contribution to this Plan that is made to a Participant Account or Employer Account; and

4.3.2 Adjust each Participant Account and Employer Account upward or downward, by an amount equal to the net income or loss accrued under this Plan with respect to the Account; and

4.3.3 Charge to each Participant Account and Employer Account applicable fees, payments or distributions made under this Plan to or for the benefit of the Participant (or his Dependent or surviving spouse) or the Employer or which are otherwise allocable to the account that have not been charged previously.

4.4 Investment of Participant and Employer Accounts. The Trustee shall determine the options to be made available through the Trust for the holding and investment of Participant Accounts and Employer Accounts. For Participant Accounts, each Participant shall elect one or more investment options into which funds in their Participant Account or Accounts shall be allocated. For each Employer Account, the Employer (or the Trustee or other Qualified Investment Manager as appointed by the Employer) shall elect one or more investment options into which the funds in the Employer Account will be allocated, based upon information provided by the Employer as to the overall investment policies and goals for the Employer Account. Participant elections shall be made and changed in accordance with procedures established by the Administrator and as may be amended from time to time. In the event no Participant Enrollment File is received, or a Participant Enrollment File is received and no election has been made with respect to a Participant Account or Employer Account, such Account shall be invested in one or more options whose investment objective is stable value. In the event funds in any Participant Account are forfeited and the Administrator has not received instructions from the Employer for the re-allocation of such funds, such forfeited funds shall be invested in one or more options whose investment objective is stable value. Separate investments

shall not be required to be maintained with respect to separate Participant Accounts or Employer Accounts; rather, investment options elected for each Employer Account and Participant Account may be aggregated and invested on an omnibus basis, together with assets of other health reimbursement arrangement plans and trusts administered by the Administrator for governmental employers in the State of Indiana. The Administrator shall maintain for the Trustee separate and distinct sub-accounting records for each Employer Account and Participant Account such that each shall have a divided interest in specific securities held by the Trust. No Employer or Participant shall have any interest in the specific securities held by the Trust on behalf of any other Employer or Participant.

4.5 Use of Participant Accounts. Amounts credited to a Participant Account shall be available to provide Benefits with respect to the Participant or his or her Dependents on and after the Claim Eligibility Date. Any amounts allocated to a Participant Account that are forfeited pursuant to the terms of this Plan or the Employer Adoption Agreement will be applied as provided in Section 4.7.

4.6 Use of Employer Accounts. Amounts credited to an Employer Account are to be applied in any manner permitted under the Employer Adoption Agreement and by IRC § 501(c)(9), and in accordance with the rules, policies and procedures established by the Administrator.

4.7 Forfeited or Unclaimed Accounts. If a positive balance remains in any Participant Account under any of the following circumstances, the remaining balance in such Participant Account shall be forfeited and transferred to a temporary forfeiture account held within the Trust on behalf of all Participants of the deceased or forfeiting Participant's Employer within the Trust, to be re-contributed as future contributions to Participants eligible for contributions or otherwise applied, as directed by the Employer, in all cases to the fullest extent permitted by applicable law and subject to the rules, policies and procedures established by the Administrator:

4.7.1 After the death of the Participant and at a time when there are no Dependents or other persons entitled to receive benefits from such Participant Account (including the circumstance where vesting occurs as a result of the death of the Participant in accordance with any applicable Collective Bargaining Unit agreement, Employer policy, or other statement or action of the Employer) as described in Section 5.1.4; or

4.7.2 If, during a continuous period equal to thirty (30) days less than the shorter of (i) the statutory period for forfeiture under the applicable State unclaimed property statute for such the Participant Account and (ii) three years, the following conditions exist:

4.7.2.1 Such Participant Account is vested and the Participant is Claims-Eligible;

4.7.2.2 No contributions to or withdrawals from the Participant Account have occurred;

4.7.2.3 No communications or other expressions of interest have been received by the Plan on behalf of the Participant of such Participant Account; and

4.7.2.4 During such period at least two communications from the Plan to the Participant have been returned as undeliverable.

4.7.3 After the Participant for whom such Participant Account is established shall have been unable to submit claims for reimbursement pursuant to Section 5.1.2 hereof for at least three years from the Claims Eligibility Date for such Participant because the Participant or the Employer has failed to submit a properly complete Participant Enrollment File.

4.7.4 Any other circumstance specified in this Plan or the Employer Adoption Agreement that results in the forfeiture of the account balance in any Participant Account.

4.8 Splitting Participant Account Upon Court Order or Agreement. To the extent permitted by applicable law, in the event of a Participant's divorce, a Participant Account may be split between the Participant and his or her former spouse upon receipt of a court order or agreement acceptable to the Administrator and subject to the policies and procedures of the Administrator; provided, however, the Administrator shall have the right not to split such account if it determines, in its sole discretion, that splitting of accounts upon divorce would result in disqualification of or adverse tax consequences for the Plan or Trust. The Administrator may value, report, withhold, and pay applicable taxes or other fees and charges in accordance with this Plan Document, the Administrator's policies and procedures, and applicable law.

4.9 Notify the Plan of Errors within Ninety (90) Days. Participants and Employers should regularly review account information and immediately report any potential errors to the Administrator. If the Administrator does not receive notification of an account error within ninety (90) days from the date the potential account error is viewed by the applicable Participant or Employer online through the Plan portal or first appears on an account statement or other report received by the applicable Participant or Employer, the Participant Account and/or Employer Account will be considered correct. Notification of any potential errors should be in writing in accordance with Section 4.9.1 below.

4.9.1. Contents of Error Notification. Written notice of any potential account error must include: (1) the name of the Employer or Participant; (2) the applicable account number; and (3) a detailed description of the error, including any applicable dollar amounts and why the Participant or Employer believes it to be an error.

4.9.2 Investigation of Error. The Plan will perform a timely investigation of any error notifications. The affected Participant(s) and/or Employer(s) will be notified regarding the results of the Plan's investigation and any corrective actions taken in accordance with the policies and procedures of the Administrator or as directed by the Trustees.

4.10 Reliance Upon Data and Information from Participants and Employers. It is the responsibility of Participants and Employers in submitting data and information to the Plan to ensure that such data and information is correct. The Plan and its agents may rely upon any data or information submitted from a Participant or Employer as true and correct. The Plan and its agents are not responsible for any errors made by a Participant or Employer with regard to the data or information submitted to the Plan, nor are the Plan and its agents responsible for further errors that result from incorrect data or information submitted by a Participant or Employer. If a Participant or Employer discovers that information or data submitted to the Plan was incorrect, it is the responsibility of that Participant or Employer to timely notify the Plan in writing and correct the information or data.

ARTICLE V.

Qualified Health Care Expenses and Benefits under this Plan

5.1 Benefits for Qualified Health Care Expenses. Benefits must be reimbursement for medical care expenses as defined by IRC § 213(d) and excludable from income under IRC §§ 105 and 106, as amended from time to time, subject to the limitations, terms, and conditions below and any other limitations, terms, and conditions under this Plan document, applicable law, or as otherwise provided in policies and procedures of the Administrator. Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s), subject to the limitations under this this Plan document. Benefits shall include (but are not limited to) Premium Reimbursements directly to the Participant.

5.1.1 General Limitations.

5.1.1.1 Reimbursements are limited to medical care expenses not covered by Social Security, Medicare, or any other health insurance contract or plan. Benefits may not include reimbursement for expenses that are deducted by the Participant, or provided to the Participant on a pre-tax basis, under any section of the IRC, or for expenses which were incurred prior to becoming a Participant of the Plan. Reimbursement may be made for premiums due for any part of Medicare or Medicare supplement policies.

5.1.1.2 Participants who are covered by an IRC § 125 healthcare flexible spending account which provides benefits covered under this Plan must exhaust benefits under the IRC § 125 plan prior to filing a request for Benefits under this Plan.

5.1.1.3 Limited HRA Coverage is available to Participants or Dependents who desire to limit their Benefits to coordinate with other benefit plans or limitations or other benefits allowed under applicable law. Limited HRA Coverage shall be subject to the terms and conditions of the Limited HRA Plan document, limitations and provisions of applicable law, and rules, regulations and limitations established by the Administrator from time to time.

5.1.1.4 Reimbursement for any claim submitted in accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement.

5.1.1.5 Except as otherwise provided under Section 2.2, benefits under this Post-separation Benefits Plan are not permitted for any Qualified Health Care Expenses incurred prior to the date a Participant becomes Claims-Eligible and retired or otherwise separated from service from the Employer who made contributions on behalf of the Participant or for Qualified Health Care Expenses incurred during any period that a Participant is Re-employed with the Employer who made contributions on behalf of such Participant.

5.1.1.6 Pursuant to an election of the Employer in the Employer Adoption Agreement and subject to the other limitations under this Article and applicable law, the Employer may choose to limit one or more Participant Accounts of any group of Participants to Premium Reimbursements only. In addition, the Employer may, pursuant to an election or amendment of the Employer Adoption Agreement accepted in writing by the Administrator, impose any other limitations or restrictions to the payment or reimbursement of Qualified Health Care Expense as necessary or desirable to coordinate with other benefit plans of Participants or to comply with applicable laws or regulations.

5.1.2 Claims for Benefits. Subject to the policies and procedures of the Administrator and the terms of any applicable Collective Bargaining Unit agreement, Employer policy, and Employer Adoption Agreement, a Participant may file claims for Benefits for medical care expenses incurred at any time on or after the Claims Eligibility Date for any Participant Account, but only to the extent that such Participant Account has a positive account balance, and provided that, before any claim may be submitted to the Administrator for reimbursement, the Administrator must have received (i) a complete Participant Enrollment File and (ii) any additional information that, in the discretion of the Administrator, is required or necessary for the Plan to comply with applicable law, including without limitation, the reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA).

5.1.3 Payment of Benefits. Payment of Benefits shall be made in accordance with the rules, regulations and limitations established by the Administrator from time to time consistent with the requirements of the Internal Revenue Code and any other applicable law.

5.1.4 Dependent Medical Benefits in the Event of Death. If a Participant dies with a vested, positive account balance in any vested Participant Account (including the circumstance where vesting occurs as a result of the death of the Participant in accordance with any applicable Collective Bargaining Unit agreement, Employer policy, or other statement or action of the Employer), his/her surviving spouse, if any, may file claims for Benefits incurred by the Participant and any Dependents, including the surviving spouse, until such account balance is exhausted. If a Participant dies without a surviving spouse

and with other Dependent(s), then the executor or administrator of the Participant's estate may file claims for any eligible expenses incurred by the Participant, and the guardian(s) of the Dependent(s) may file claims for eligible Benefits on behalf of the Dependent(s) until such account balance is exhausted. If a positive balance remains in any Participant Account after the death of the last to die of a deceased Participant's surviving Dependents, or if the deceased Participant has no surviving Dependents, then the account balance (after payment of any remaining Benefits of such deceased person) will be forfeited and applied in accordance with Section 4.7. The provisions of this section shall be administered pursuant to rules established by the Administrator.

5.2 Termination of Benefits. All benefits with respect to any Participant Account will terminate when the Participant loses his or her active status with respect to such Participant Account pursuant to Section 2.4.

ARTICLE VI.

General Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for Benefits or to any surviving Dependent for Benefits in the event of the Participant's death under the Plan shall be limited to the balance in such Participant's Account. Neither the Sponsor, Trustee, Administrator or Employer, nor any of their agents, officers, or employees, shall be responsible for confirming or enforcing the terms of collective bargaining agreements, Employer policies, or other agreements regarding the terms of a Participant's eligibility to participate or amounts to be contributed on behalf of a Participant under this Plan or to pay Benefits under the Plan in excess of the balance in the applicable Participant Account or such other limits as may apply based upon the Employer's plan design and applicable law.

6.2 Reserved.

6.3 Reserved.

6.4 Procedures for Claims, Internal Appeals, and External Review. The following provisions of this Section 6.4 set forth the procedures for claims, internal appeals of Adverse Benefits Determinations, and external review of Final Internal Adverse Benefits Determinations. These procedures shall be strictly adhered to by the Administrator and each Claimant under this Plan, and no judicial proceedings with respect to any request for benefits hereunder may be commenced by any such Claimant until the procedures for claims and internal appeals of Adverse Benefits Determinations set forth herein have been followed and exhausted in full; provided, however, that any timeframe requirements or limitations applicable to the Plan or the Administrator may be voluntarily extended in writing by the Claimant in the Claimant's sole discretion; and any timeframe requirements or limitations applicable to the Claimant may be voluntarily extended in writing by the Administrator in the Administrator's sole discretion.

6.4.1 Claims. A person claiming benefits under the Plan, which may include a Participant or such Participant's Dependent, or any such person's authorized representative

(referred to in this section as the "Claimant"), shall deliver a request or claim for such benefits in writing to the Administrator. The Administrator shall review the Claimant's request or claim for benefits and shall thereafter notify the Claimant of its decision as follows:

6.4.1.1 The Administrator shall provide the Claimant with written notice of its determination regarding the Claimant's request for benefits not later than thirty (30) days after the date the Administrator receives the Claimant's request for benefits, unless circumstances beyond the control of the Plan and the Administrator require an extension of time for reviewing such claim. In the event such circumstances require an extension of time for reviewing the Claimant's request for benefits, the Administrator shall, prior to the expiration of the initial thirty (30)-day period referred to above, provide the Claimant with written notice of the extension and of the circumstances that require such extension and of the date by which the Administrator expects to render its determination. In no event shall such extension exceed a period of fifteen (15) days after the date of the expiration of the initial thirty (30)-day period, totaling forty-five (45) days at a maximum after the date the Administrator receives the Claimant's request for benefits (such thirty (30) or forty-five (45)-day period being referred to herein as the "Initial Review Period").

6.4.1.2 If the Claimant's request for benefits is approved by the Administrator, the Administrator shall notify the Claimant of such approval and proceed to process the request for benefits.

6.4.1.3 In the event the Administrator determines that additional information is required to review a claim, the Administrator shall, as soon as practicable but not later than the expiration of the applicable Initial Review Period, provide the Claimant with written notice of its need for additional information ("Notice of Incomplete Claim") and the need for an extension of time to allow the Claimant sufficient time to gather and provide such additional information. The Notice of Incomplete Claim shall specifically describe the required information and provide the Claimant with forty-five (45) days after the date the Claimant receives such Notice of Incomplete Claim (the "45-Day Response Period") to provide such additional information to the Administrator. If the Claimant fails to respond with additional information before the expiration of the 45-Day Response Period, the claim shall be deemed to have received an Adverse Benefits Determination as of the day immediately following the expiration of the 45-Day Response Period, and the Notice of Incomplete Claim may include a provisional Adverse Benefits Determination that would take effect automatically under such circumstances. If, within the 45-Day Response Period, the Claimant provides additional information (whether or not such additional information is determined by the Administrator to be sufficient to make a benefits determination), then the Administrator shall provide the Claimant with written notice of its determination not later than fifteen (15) days after the date the Administrator receives such additional information, regardless of whether either the Initial Review Period or the 45-Day Response Period will not yet expire prior to such fifteen (15) day period (such new review period shall be

referred to herein as the "Incomplete Claim Review Period" and shall override the Initial Review Period under the circumstances described in this paragraph).

6.4.1.4 In the event of an Adverse Benefits Determination, the Administrator shall provide written notice of such Adverse Benefits Determination and shall include in such notice, set forth in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant, the following:

(a) The specific reason or reasons for the Adverse Benefits Determination and sufficient information to identify the claim involved, if any, including the date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes;

(b) Specific references to pertinent Plan provisions or IRS rules and regulations on which the Adverse Benefits Determination is based;

(c) An explanation of the Claimant's right to appeal such Adverse Benefits Determination and to have such appeal reviewed by someone other than (i) the individual who made the initial Adverse Benefits Determination or (ii) such person's subordinate;

(d) A description of any additional material or information necessary for the Claimant to perfect the claim or appeal the Adverse Benefits Determination and an explanation of why such material or information is necessary;

(e) An explanation of the Claimant's right to review the claim file and to present additional evidence, comments, or testimony as part of the appeals process;

(f) A description of available internal appeals procedures, including information regarding how to request a review of an Adverse Benefits Determination pursuant to Section 6.4.2 below and the timeframe within which to submit such a request;

(g) At no cost to the Claimant, copies of any additional evidence considered, relied upon, or generated by the Plan or the Administrator in connection with its review of the claim and an opportunity for the Claimant to respond to such additional evidence within the one hundred eighty (180)-day time period within which to appeal the Adverse Benefits Determination as described in Section 6.4.2.

(h) An explanation of the availability of, and contact information for, an applicable office of health insurance consumer assistance or

ombudsman to assist with the internal claims and appeals and external review procedures.

6.4.1.5 In the event that neither an approval of benefits nor Adverse Benefits Determination is received or deemed received by the Claimant before the expiration of the Initial Review Period or the Incomplete Claim Review Period (whichever is applicable), the claim shall be deemed to have received an Adverse Benefits Determination as of the day immediately following the expiration of such applicable review period.

6.4.2 Internal Appeals of Adverse Benefits Determinations.

6.4.2.1 In the event an Adverse Benefits Determination has been received or deemed received by a Claimant, the Claimant may appeal such Adverse Benefits Determination by submitting to the Administrator a written request for a review of such Adverse Benefits Determination. Any such written request for review must be delivered to the Administrator not later than one hundred eighty (180) days after the date the Claimant receives written notification of the Adverse Benefits Determination or from the date the Claimant was deemed to have received an Adverse Benefits Determination for such claim.

6.4.2.2 During the period prescribed in paragraph 6.4.2.1 for filing a request for review of an Adverse Benefits Determination, the Administrator shall permit the Claimant to review the claim file and other pertinent documents and submit written issues and comments concerning the Claimant's claim.

6.4.2.3 Upon receiving a request by a Claimant for a review of an Adverse Benefits Determination, the Administrator shall review such Adverse Benefits Determination promptly, and shall provide written notice to the Claimant of its determination within sixty (60) days after the date on which the Administrator received the request for review of such Adverse Benefits Determination.

6.4.2.4 If the Claimant's request for benefits is approved by the Administrator upon review of the Adverse Benefits Determination, the Administrator shall notify the Claimant of such approval and proceed to process the request for benefits.

6.4.2.5 If in connection with its review of an Adverse Benefits Determination, the Administrator considered, relied upon, or generated any new or additional evidence or rationale for a Final Internal Adverse Benefits Determination, the Administrator shall, as soon as practicable but not later than thirty (30) days after the date the Administrator receives the Claimant's request for review of such Adverse Benefits Determination, provide the Claimant with written notice of such new evidence or rationale ("Notice of New Information") and the opportunity for the Claimant to provide a written response to such new evidence or rationale not later than fifteen (15) days after date the Claimant receives such Notice

of New Information (the "15-Day Response Period"). If the Claimant fails to provide a written response before the expiration of the 15-Day Response Period, the claim shall be deemed to have received an Final Internal Adverse Benefits Determination as of the day immediately following the expiration of the 15-Day Response Period, and the Notice of New Information may include a provisional Final Internal Adverse Benefits Determination that would take effect automatically under such circumstances. If within the 15-Day Response Period, the Claimant provides a written response to such new evidence or rationale, then the Administrator shall provide the Claimant with written notice of its determination not later than (i) fifteen (15) days from the date of the Administrator's receipt of such written response or (ii) sixty (60) days from the date on which the Administrator received the request for review of such Adverse Benefits Determination, whichever occurs first.

6.4.2.6 The Administrator shall provide written notice to the Claimant of a Final Internal Adverse Benefits Determination and shall include in such notice, set forth in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant, the following:

(a) The specific reasons for its decision and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes;

(b) Specific references to the pertinent Plan provisions or IRS rules and regulations on which the Final Internal Benefits Determination is based;

(c) A description of available external review processes, including information regarding how to request an external review of the Final Internal Adverse Benefits Determination pursuant to Section 6.4.3 below, and the timeframe within which to submit such a request; and

(d) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist Claimants with the external review procedures.

6.4.2.7 In the event that neither an approval of benefits nor a Final Internal Adverse Benefits Determination is received or deemed received by the Claimant within sixty (60) days after the date the Administrator receives the written request for review of the Adverse Benefits Determination, the claim shall be deemed to have received a Final Internal Adverse Benefits Determination as of the sixty-first (61st) day following the date Administrator received the written request for review of the Adverse Benefits Determination.

6.4.3 <u>External Review of Final Internal Adverse Benefits Determinations</u>.

6.4.3.1 After receipt or deemed receipt of a Final Internal Adverse Benefits Determination, a Claimant may file a written request for an external review of such Final Internal Adverse Benefits Determination. Any such request for review must be delivered to the Administrator not later than the first day of the fifth month following the date the Claimant receives or is deemed to receive a Final Internal Adverse Benefits Determination. If such request for external review deadline falls on a Saturday, Sunday, or other non-business day, then the request for external review must be delivered to the Administrator not later than the next calendar day that is not a Saturday, Sunday, or other non-business day (the "Initial External Review Filing Deadline").

6.4.3.2 Within five (5) business days after receiving the external review request, the Administrator must complete a preliminary review to determine if:

(a) the Claimant was covered under the Plan,

(b) the Claimant provided all the information and forms necessary to process the external review,

(c) the Claimant has followed and exhausted the internal appeals procedures, and

(d) the Final Internal Adverse Benefits Determination related to the failure of the Claimant to meet eligibility requirements under the Plan, as Final Internal Adverse Benefits Determinations based upon a failure to meet eligibility requirements are not subject to external review.

6.4.3.3 Within one (1) business day after completion of its preliminary review, the Administrator shall provide written notice to the Claimant of the outcome of its review. If the Claimant's request for external review is complete but the Final Internal Adverse Benefits Determination is not eligible for external review, the notice must state the reasons for ineligibility and include contact information for the Department of Health and Human Services Insurance Assistance Team (HIAT). If the Claimant's request for external review is incomplete, the notice must describe the information and materials needed to complete the request, and the Claimant shall be permitted to complete the request not later than the Initial External Review Filing Deadline or forty-eight (48) hours after the Claimant's receipt of the preliminary review notice, whichever is later.

6.4.3.4 If the Administrator receives a timely, completed request for external review of a Final Internal Adverse Benefits Determination that is eligible for review in accordance with the requirements of this Section 6.4.3, the Administrator shall assign an Independent Review Organization (IRO) to review the claim, using a method of assignment that assures the independence and impartiality of the assignment process. The IRO shall be required to provide written notice to the Claimant stating that:

(a) The Claimant's request is eligible for external review and has been assigned to such IRO;

(b) The Claimant has the right to submit additional information in writing to the IRO within ten (10) business days after the date the Claimant receives such notice and, if the IRO receives such additional information within ten (10) business days after the Claimant receives such notice, then (i) the IRO must consider such additional information in its external review, and (ii) the IRO is required to forward such additional information submitted by the Claimant to the Administrator within one (1) business day after the date the IRO receives such information;

6.4.3.5 Within five (5) business days after the date the IRO receives the external review assignment, the Administrator is required to provide the IRO with all documents and information considered by the Administrator in making its Adverse Benefits Determination and Final Internal Adverse Benefits Determination;

6.4.3.6 Upon receiving from the IRO any additional information submitted by the Claimant, the Administrator may reconsider the Final Internal Adverse Benefits Determination. If the Administrator reverses the Final Internal Adverse Benefits Determination upon such review, it must notify the Claimant and the IRO within one (1) business day after making such reversal, and the IRO must terminate its external review;

6.4.3.7 The IRO is not bound by the prior Adverse Benefits Determination or Final Internal Adverse Benefits Determination of the Administrator in making its external review decision.

6.4.3.8 Within forty-five (45) days after the IRO receives the external review request, the IRO must provide written notice of the final external review decision to the Claimant and the Administrator. Such notice shall include the following information:

(a) A general description of the reason for the external review request, including information sufficient to identify the claim, including the date(s) of service, the provider, the claim amount (if any), and the reason for the prior denial;

(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 considered in reaching the decision, including specific coverage provisions and evidence-based standards;

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

(e) A statement that the IRO's decision is binding, unless other remedies are available to the Plan or the Claimant under state or Federal law;

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

(g) A phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

6.4.3.9 An external review decision by the IRO upholding the Administrator's Final Internal Adverse Benefits Determination is binding on the Claimant but does not prohibit the Claimant from subsequently pursuing other remedies available under state or federal law. If the IRO reverses the Administrator's Final Internal Adverse Benefits Determination, the Plan is required by law to provide reimbursement for the claim without delay; provided, however, that the Plan shall still be entitled to subsequently pursue other legal remedies that may be available under state or federal law.

6.5 Reserved.

6.6 Protected Health Information. The Plan shall comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and the Omnibus Rule of 2013 with respect to protecting the privacy and security of Protected Health Information (PHI).

6.6.1 Plan Uses of Protected Health Information. The Plan shall adhere to procedures regarding the permitted and required uses by, and disclosures to, the Plan of PHI for plan administrative and other permitted purposes. The Plan shall:

6.6.1.1 not use or disclose PHI other than as permitted by the Plan documents or as required by law;

6.6.1.2 ensure that any agents, subcontractors or business associates to whom the plan provides PHI shall agree to the same restrictions that apply to the Plan;

6.6.1.3 not use or disclose PHI for purposes other than the minimum necessary to administer the Plan;

6.6.1.4 report to the privacy official any known use or disclosure that is inconsistent with permitted use and disclosures;

6.6.1.5 make PHI available to Plan participants, consider their amendments, and, upon request, provide them with an accounting of PHI disclosures in accordance with the HIPAA privacy rules;

6.6.1.6 make internal records relating to the use and disclosure of PHI available to the Department of Health and Human Services upon request; and

6.6.1.7 the Plan shall destroy PHI in accordance with its Document Retention and Destruction Policy when the Plan is no longer required to maintain PHI.

6.7 Employer Uses of Protected Health Information.

6.7.1 HIPAA Plan Amendment. Members of the workforce of an Employer may have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Employer, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI. The provisions of Section 6.7 shall constitute the "HIPAA Plan Amendment" required by and incorporating the provisions of 45 CFR §164.504(f)(2)(ii).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI and Electronic PHI.

The following HIPAA definitions of PHI and Electronic PHI apply to this HIPAA Plan Amendment:

"Protected Health Information (PHI)" means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. Protected health information includes information of persons living or deceased and also includes Electronic PHI.

"Electronic Protected Health Information (Electronic PHI)" means Protected Health Information that is transmitted by or maintained in electronic media.

An Employer shall have access to PHI and Electronic PHI from the Plan only as permitted under this HIPAA Plan Amendment or as otherwise required or permitted by HIPAA.

6.7.2 Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to an Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

Enrollment and disenrollment information shall include, without limitation, name, employee ID or social security number, contribution history, account balance information, age, employment status (active, retired, separated), limited account status, account preferences (e-communication, etc.) or other information necessary to determine, verify, or assist with eligibility, enrollment or disenrollment of an Employee or Participant.

The Plan and each Employer acknowledge and agree that enrollment and disenrollment information is information of the Employer and is held on behalf of the Employer by the Plan. Enrollment and disenrollment information held at any time by the Employer is held in its capacity as an Employer and is not PHI.

6.7.3 Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to an Employer, provided that the Employer requests the Summary Health Information for the purpose of (1) obtaining premium bids from service providers or health plans for providing services or health coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

"*Summary Health Information"* means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

6.7.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 6.7.5 and obtaining written certification pursuant to Section 6.7.8, the Plan may disclose PHI and Electronic PHI to an Employer, provided that the Employer uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

6.7.4.1 *"Plan Administration Purposes"* means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing and appeals, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer or any employment-related actions or decisions.

6.7.4.2 Enrollment and disenrollment functions performed by the Employer are performed on behalf of Employees, Plan Participants and Dependents, and are not Plan administration functions.

6.7.4.3 Notwithstanding any provisions of this Plan to the contrary, in no event shall an Employer be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

6.7.5 Conditions of Disclosure for Plan Administration Purposes. Each Employer agrees that with respect to any PHI it receives pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) disclosed to it by the Plan, such Employer shall:

6.7.5.1 not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

6.7.5.2 ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

6.7.5.3 not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

6.7.5.4 report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

6.7.5.5 make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;

6.7.5.6 make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

6.7.5.7 make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

6.7.5.8 make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

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

6.7.5.10 ensure that adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR §504(f)(2)(iii), is established.

6.7.6 Additional Requirements. Each Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan or in connection with a Plan Administration Purpose, it will:

(a) 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 Plan;

(b) ensure that the adequate separation (i.e., the firewall) between employees of the Employer who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to the Plan any security incident of which it becomes aware, as follows: Employer will report to the Plan, with such frequency and as soon as feasible, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Employer will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

6.7.7 Adequate Separation Between Plan and Employer and Between Employees Who Perform Plan Administration Functions and Employees Who Do Not Have Plan Administration Functions. Any Employer that receives any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 below (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that

complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) from the Plan shall allow access to the PHI to only those employees or classes of employees identified on the Employer's HIPAA Compliance Certificate required by this HIPAA Plan Amendment. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this HIPAA Plan Amendment, the employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

6.7.7.1 The Employer shall ensure that the provisions of this HIPAA Plan Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

6.7.8 Certification of Employer. The Plan shall disclose PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) to an Employer only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer acknowledging that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 6.7.5 and all other conditions and requirements of this HIPAA Plan Amendment.

ARTICLE VII.

Administrator

7.1 Rights & Duties. The Administrator shall enforce this Plan in accordance with its terms, shall be charged with its general administration and shall establish such rules, policies and procedures which it deems appropriate for the administration of the Plan. The Administrator shall have the power and discretion to accomplish the purposes of the Plan, including but not limited to the power:

7.1.1 To determine all questions relating to the eligibility of Employees to participate in the Plan.

7.1.2 To determine entitlement to benefits under the provisions of Articles 5 and 6.

7.1.3 To compute and certify to the Employer the amount and kind of benefits payable to or with respect to Participants.

7.1.4 To maintain all the necessary records for the administration of this Plan other than those maintained by the Employer or the Trustee.

7.1.5 To prepare and file or distribute all reports and notices required by law with respect to the Plan and Trust.

7.1.6 To authorize all the disbursements from the Trust.

7.1.7 To inform the Trustee with respect to the investment of Participant Accounts.

7.1.8 To interpret Plan provisions and Employer Adoption Agreements.

7.1.9 To make and publish such rules, policies and procedures for the administration of this Plan that are not inconsistent with the terms hereof.

7.2 Information. To enable the Administrator to perform its functions, the Employer shall supply it with full and timely information on all matters relating to Employer contributions with respect to Participants and the Employee's eligibility to participate in the Plan. The Administrator shall maintain such information and advise the Employer of such other information as may be pertinent to the administration of the Plan and Trust. The Administrator shall have neither the right nor the obligation to interpret the provisions of any Collective Bargaining Unit agreement, Employer policy, or other statement or action for the purpose of performing its duties under the Plan or the Trust, and the Trustee and Administrator shall have the right to rely on information provided by the Employer pursuant to this section with respect to Employee eligibility and other applicable information contained in such Collective Bargaining Unit agreement, Employer policy, or other statement or action.

7.2.1 The Administrator shall forward to each Participant, information relative to his/her Participant Account or Accounts and how to request payment of benefits upon becoming a Participant in the Plan. The information will include a summary of the Plan, including claim procedures and forms. The Administrator shall also mail a written acknowledgement to the Participant within a reasonable amount of time after receipt of the initial contribution with respect to the Participant, acknowledging establishment of the Participant Account or Accounts and confirmation of the amount received.

7.2.2 The Administrator shall provide a published statement at regular intervals which shall include the following information: The Participant's name and address; contributions received and the month the amount was posted to the Participant Account or Accounts; total Participant Account value at statement date; income earned or other gain or loss; all payout and disbursement amounts, and increases or decreases for expenses or benefit payments; ending/forward balance; and e-mail address and contact telephone number for error corrections or questions regarding the statement.

7.3 Expenses of Consultants, Investment Managers, Administrators, Lawyers, Accountants, Agents, Actuaries and Other Service Providers. The Employer agrees that the Administrator shall be entitled to compensation payable from Trust assets at the rate of compensation provided for in the Employer Adoption Agreement. The Administrator may employ such consultants, investment managers, administrators, lawyers, accountants, agents, actuaries and

other service providers as it reasonably deems necessary or appropriate in carrying out administration of the Plan, the cost of which shall be considered Plan administration expenses. Such expenses, together with all other reasonable expenses of administration of the Plan, including but not limited to fees and expenses for: legal, benefits staff, auditing, printing, postage, mail service, plan administration software or technology, Trustee, bank, third-party administrator, consultant and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Trust, the Plan, the Trustee, or Participants, may be paid through a reduction of investment earnings and/or reasonable fees and assessments from Participant Accounts, as determined by the Administrator in the exercise of its discretion.

7.4 Liability Limitation. The Sponsor, Administrator, Employers and Trustee, and their agents, officers and employees shall not be liable for the acts or omissions to act of any investment manager appointed to manage the assets of the Plan and Trust. The Administrator and Sponsor shall not be liable for the acts or omissions to act of any investment manager appointed to manage the assets of the Plan and Trust if the Administrator or Sponsor in appointing such manager acted with reasonable care and diligence under the circumstances then prevailing that a reasonable person would use in the conduct of an enterprise of a like character and with like aims. Any service provider retained by the Administrator shall be liable only for its own acts or omissions in providing services to the Plan and Trust, and it shall not be liable for the acts or omissions of any other service provider that is performing services for the Plan and Trust.

7.5 Notices & Directions. The address for delivery of all communications to the Administrator shall be:

HRA Administrator, LLC
906 W 2nd Avenue, Suite 400
Spokane, WA 99201-4502
(509) 838-5571
(509) 838-5613 Fax

7.6 Funding Policy & Procedures. The Sponsor shall formulate any policies, practices, and procedures it deems appropriate to carry out the funding of the Plan.

ARTICLE VIII.

Amendment & Termination

8.1 Permanency. It is the expectation of the Sponsor that this Plan will be continued indefinitely, but continuance of this Plan is not assumed as a contractual obligation of the Sponsor, Administrator, Employers or Trustee. This Plan may be amended or terminated only as provided in this Article.

8.2 Amendments.

8.2.1 Subject to Section 8.3 hereof and Section 8.2 of the Trust, the Sponsor shall have the right to amend this Plan from time to time, and to amend or cancel any such amendments.

8.2.2 Amendments shall be as set forth in an instrument in writing executed by the Sponsor. Any amendment may be current, retroactive, or prospective, in each case as provided therein.

8.2.3 The Administrator shall deliver to the Employers notice of any amendment within 90 days after the effective date thereof.

8.3 Limitation on Amendment.

8.3.1 The Sponsor shall make no amendment to this Plan which shall permit any part of the Trust property to revert to an Employer or be used for or be diverted to purposes other than the exclusive benefit of Participants except to the extent permitted by IRC § 501(c)(9) and any other applicable law and as will not result in the imposition of an excise tax under IRC § 4976.

8.3.2 If any amendment affects the Trustee's duties or responsibilities, it must be approved in writing by the Trustee.

8.3.3 Without prior written consent of a majority of Employers, the Sponsor shall make no amendment to this Section 8.3.3 or to the Employer's right to terminate its contributions, or transfer or roll-over assets, under Section 8.4 hereof and Section 8.3 of the Trust.

8.4 Discontinuance/Termination of Contributions. This Plan does not prohibit Employers from discontinuing or terminating contributions to the Plan without prior notice unless contrary to law. The Employer acknowledges and agrees that although it can discontinue or terminate contributions to the Plan and Trust and can terminate its participation in the Trust upon written notice to the Administrator, assets already contributed to the Trust cannot be withdrawn or transferred other than a transfer or rollover: (a) to a trust recognized by the IRS to be qualified under IRC § 501(c)(9), (b) which does not reduce the amount of any Participant Account, (c) which is not in violation of IRC § 501(c)(9) or IRC § 4976 or other applicable law, (d) pursuant to an agreement in which the Employer either (i) agrees to hold the Plan, Trust, Trustee, Sponsor, and Administrator and their officers, agents and employees harmless and indemnify them for any loss or liability resulting from the transfer or (ii) represents and warrants to the Plan, Trust, Trustee, Sponsor, and Administrator that such transfer or rollover complies with the requirements of this section, and (e) subject to the fee schedule then in effect with respect to such transfers.

8.5 Termination of Plan. Unless contrary to law, the Sponsor shall have the right to terminate this Plan and the Trust upon ninety (90) days' prior written notice to the Trustee and each Employer. Such written notice shall state the Sponsor's decision to terminate this Plan and the Trust and direct the Trustee as to the transfer or disposition of Trust assets, based on the following options, each of which shall be subject to any losses on or other contractual adjustments applicable to invested assets that may accrue or become due as a result of such disposition:

8.5.1 A direct in-kind transfer of assets to a substantially similar trust;

8.5.2 A series of installment payments over a set period of time of assets from the Trust attributable to this Plan to another IRC § 501(c)(9) trust;

8.5.3 A cash payment to another IRC § 501(c)(9) trust or another program providing Benefits for the Participants of this Plan; or

8.5.4 Any other method permitted by IRC § 501(c)(9).

8.6 Replacement of the Plan Sponsor. If for any reason the person or entity who acts as the Sponsor shall resign, such person (the predecessor Sponsor) shall forthwith recommend for appointment a successor Sponsor by giving notice to the Employee Representatives at least thirty (30) days in advance of the proposed effective date of such appointment. A majority of the Employee Representatives may veto the predecessor Sponsor's appointment of a successor Sponsor through an instrument in writing delivered within twenty (20) days following the delivery of notice of such appointment by the predecessor Sponsor. If within twenty (20) days following the delivery of such notice by the predecessor Sponsor, the majority of the Employee Representatives have not by instrument in writing vetoed such appointment of the successor Sponsor, such appointment shall be deemed to have been approved by the Employee Representatives. Any successor Sponsor appointed hereunder shall execute, acknowledge, and deliver to the predecessor Sponsor and Trustee an instrument in writing accepting such appointments hereunder. Such successor Sponsor thereupon shall become vested with the same powers and duties with respect to the Plan, as are hereby vested in the original Sponsor. The predecessor Sponsor shall execute all such instruments and perform all such other acts as the successor Sponsor shall reasonably request to effectuate the provisions hereof. The successor Sponsor shall have no duty to inquire into the administration of the Plan for any period prior to its succession. No Sponsor shall have any liability, duty, or other obligation with respect to actions or omissions of any successor or predecessor Sponsor.

ARTICLE IX.

Miscellaneous

9.1 Conflicting Provisions. This Plan, the Trust, the Employer Adoption Agreement and the applicable Participant Enrollment File are all parts of a single, integrated employee benefit system and shall be construed together. In the event of any conflict between the terms of these documents, such conflict shall be resolved first by reference to the Trust, except as more

specifically addressed in the Plan, then the Plan, then the Employer Adoption Agreement, then the applicable Participant Enrollment File, if applicable.

9.2 Applicable Law; Severability. This Plan shall be construed, administered, and governed under the laws of the State of Indiana. If any provision of this Plan shall be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

9.3 Gender & Number. Words used in the masculine shall apply to the feminine where applicable, and vice versa, and when the context requires, the plural shall be read as the singular and singular as the plural.

9.4 Headings. Headings used in this Plan are inserted for convenience of reference only, and are not to be used in interpreting the provisions.

9.5 Reserved.

9.6 Audit. The Administrator shall have an audit of the Plan conducted annually.

9.7 Limitation on Rights. Neither the establishment of this Plan, nor any modifications or amendment thereof, nor the making of any contributions to or the payment of any benefits from the Plan shall be construed as giving any Participant, Dependent or any other person any legal or equitable right against the Trustee, the Sponsor, the Administrator or any of their agents, officers and employees.

9.8 Assignment. The interest of any Participant or Dependent in the Plan or assets or any Participant Account held with respect to the Plan shall not be subject to assignment or alienation, either by voluntary or involuntary act of the person or by operation of law, and shall not be subject to assignment, attachment, execution, garnishment, or any other legal or equitable process except to the extent required by law.

9.9 Counterparts. This Plan may be adopted in an original and any number of counterparts, each of which shall be deemed to be an original of one and the same instrument.