

# **Summary Plan Description and Plan Document**

## **Defined Contribution Health Care Plan of**

---



# TABLE OF CONTENTS

## **DEFINED CONTRIBUTION HEALTH CARE PLAN OF**

**Document Execution Page**

Record of Plan Amendments

## **SCHEDULE OF TERMS AND BENEFITS**

**Certain Terms or Phrases**

**Participant Health Care Trust Account**

**Defined Contributions**

**Plan Benefits**

## **INTRODUCTION**

**In General**

**Nature of the Plan**

**Purpose of the Plan Document**

**Critical Dates**

**Plan Supervisor**

**Named Fiduciary and Plan Administrator**

**Plan Administration**

**Plan Funding**

**Federal Laws and Regulations**

## **DEFINITIONS**

Actively-At-Work

Code

College or University

Covered Expenses

Covered Person

Defined Contribution

Dependent Child

Effective Date of Coverage

Election Period

Eligibility Waiting Period

Employee

Enrollment Date

ERISA

Foster Child

Full-Time

Incurred

Late Enrollee

Participant

Participant Contributions

Participant Health Care Trust Account

Participating Employer

Plan Supervisor

Spouse

## **ELIGIBILITY**

**New Employee Eligibility**  
**Effective Date of Enrollment**  
**Other Employee Eligibility**  
**Participant Termination Date**  
**Dependent Initial Eligibility Date**  
**Dependent Termination Date**  
**Participant Elections**  
    Initial Election  
    Changing Election  
**Covered Dependents**

**PLAN BENEFITS**

**Defined Contributions**  
**Participant Contributions**  
**Paying Plan Benefits**

**ADMINISTRATION**

**General**  
**Plan Records**  
**Administrative Expenses**  
**Indemnification of Plan Administrator**

**ERISA PROVISIONS**

**Claim for Plan Benefits**  
**General Fiduciary Responsibilities**  
**Medical Privacy and Confidentiality**  
**Anti-Discrimination**

**MISCELLANEOUS**

**Amendment**  
**Termination of Plan**  
**Plan Interpretation**  
**Participant Rights**  
**Tax Consequences**  
**Notices**  
**Free Choice of Physician**  
**Misstatements**  
**Plan Amendments**

**STATEMENT OF ERISA RIGHTS**

**Certain ERISA Requirements**  
**Statement of Rights**  
**Appeals Procedures**  
**Other Items of Interest**

# SCHEDULE OF TERMS AND BENEFITS

## Certain Terms or Phrases

**Employer (and Plan Sponsor)** mean:

**Employer Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**EIN:** \_\_\_\_\_

**Tel:** \_\_\_\_\_

**Participating Employer** means: \_\_\_\_\_.

**Plan Name** means: \_\_\_\_\_.

**Plan Number** for Administration Purposes is: \_\_\_\_\_.

**ERISA Plan Number** is: \_\_\_\_\_.

**Effective Date of the Plan** is: \_\_\_\_\_ as amended and restated \_\_\_\_\_.

**Plan Supervisor** means: \_\_\_\_\_ or its successor as may be appointed by the Employer.

**Plan Administrator** means the Employer. Plan Administrator is also the Named Fiduciary and Agent of Legal Service of process. The Plan Administrator has the final authority and responsibility to review and make final decisions on Plan matters such as benefit adjudication, eligibility for coverage determinations, and interpretation of terms.

**Plan Coordinator** means: \_\_\_\_\_ or a successor as shall be named by the Employer:

**Type of Welfare Plan** means: \_\_\_\_\_.

**Plan Trustees** mean: \_\_\_\_\_.

All Employer Contributions are placed in Participant Health Care Trust Accounts.

**Plan Year** means the twelve (12) month period from \_\_\_\_\_ to \_\_\_\_\_.

Plan Year is the reporting year for ERISA purposes.

**Employee** means: \_\_\_\_\_.

**Eligibility Class** means: \_\_\_\_\_.

Eligibility class is only for employees (1) who are *not* otherwise covered by a group health care plan sponsored by this Employer or (2) who have an Archer Medical Savings Account.

**Claim Filing Period** means: \_\_\_\_\_.

**Benefit Processing Responsibility of the Plan Supervisor** means the processing of all benefits through the appeals process. The Plan Administrator is the adjudicator and recordkeeper of last resort, however.

**Re-Employment Period** means six (6) months.

**Election Period** means: \_\_\_\_\_.

**Unmarried Child's Eligibility Age** means through age 18 (that is, to such child's 19th birthday); such eligibility is extended through age 22 (that is, to such child's 23rd birthday) if such Dependent Child is a full-time student in an accredited school, college or university as listed in the most recent edition of *The Directory of Higher Education*. A child's dependent status terminates upon such child being employed full-time for wages, profit or gain.

*Full-time* is the period of attendance which the accredited school, college or university considers full-time, as determined by the rules of the educational institution.

**Physically Handicapped and/or Mentally Retarded Dependent children** will be covered regardless of age if satisfactory proof of condition is provided and approved by the Plan Supervisor.

**Participant Health Care Trust Account** *De Minimis* limits mean \$ \_\_\_\_\_.

**Eligibility Waiting Period** means: \_\_\_\_\_.

**Qualifying Hours** means: \_\_\_\_\_.

**Actively-at-Work** means performing substantial and material duties of a Participant's job while working at least \_\_\_\_\_ hours per week for the Employer.

## Participant Health Care Trust Account

The principal features of the Participant Health Care Trust Account are as follows:  
Trust Beneficiaries are the Participants and their Covered Dependents.

1. The effective date of the trust is \_\_\_\_\_.
2. Trust is established by \_\_\_\_\_.
3. Purpose of the trust is to provide protection and governance of Plan Assets created by this Plan.
4. Each Participant has a definable and distinguishable Trust Account in a Master Trust which Master Trust commingles assets for administration and investment convenience only.
5. Trustee is \_\_\_\_\_.
6. Trust property consists of net assets credited to a Participant (and Trust Beneficiary) by the Plan and Trust terms.

## Defined Contributions

Defined Contributions are those monies which are paid into Participant Health Care Trust Accounts and are deemed to be Employer-paid. Participants may contribute but their contributions become Employer contributions through a mandatory Premium Option Plan.

Attained Age of Participant	<u>Participant</u>	<u>Monthly Defined Contribution</u>		
		<u>Participant and Child</u>	<u>Participant and Spouse</u>	<u>Family</u>
To 24				
25-34				
35-44				
45-54				
55-64				
65 Over				

## Plan Benefits

Plan Benefits are withdrawals from the Participant Health Care Trust Accounts which reimburse the Participant for Covered Expenses which are defined to be medical (physician, hospital, surgery), dental, vision, hearing and prescription drug expenses otherwise deductible under IRC §213 except that Plan Benefits are not provided for Durable Medical Equipment or Devices. Plan Benefits also include premiums for individual policies providing hospital-medical-surgical benefits so long as such policies are approved in writing by the Plan Administrator.

# INTRODUCTION

## In General

The *Employer*, as set forth in the Schedule of Terms and Benefits, hereby establishes a health care plan for the benefit of eligible employees, on the terms and conditions described herein. The Plan shall be referred to by the *Plan Name*, as set forth in the Schedule of Terms and Benefits. Employer is the *Plan Sponsor* as defined by ERISA. The Plan may permit *Participating Employers*, as set forth in the Schedule of Terms and Benefits, to also use the Plan.

## Nature of the Plan

This Plan shall be referred to as a Defined Contribution Health Care Plan. Such defined contributions may be used as directed by the Participants but only for Plan Benefits set forth in the Schedule of Terms and Benefits. This Plan is supported exclusively by Employer contributions; it is Employer-administered and may be amended or terminated by the Employer. Plan contributions are tax-deductible by the Employer and not taxable to the Participants. The type of welfare plan for ERISA purposes is shown in the Schedule of Terms and Benefits.

## Purpose of the Plan Document

The purpose of this Plan document is to set forth the provisions of the Plan which provide for the payment of Plan Benefits or the reimbursement of all or a portion of eligible Covered Expenses for medical (physician, hospital, surgical), dental, hearing, vision and prescription drug Therapies.

The subject health care plan is maintained exclusively for the benefit of the Employees (and Covered Dependents) of the Employer. It is the intention of the Employer to continue the plan for an indefinite period of time. All of the rights offered the Employees hereunder are legally enforceable. All Employees are provided and have been provided a reasonable notification of benefits available in this Plan. The Plan benefits apply for an entire Plan Year, unless the Plan is otherwise terminated or amended.

## Critical Dates

The *Effective Date of the Plan* is set forth in the Schedule of Terms and Benefits. The *Reporting Year* for purposes of the federal reporting form (DOL/IRS Form 5500) means Plan Year.

## Plan Supervisor

The *Plan Supervisor*, if any, is set forth in the Schedule of Terms and Benefits. The Plan Supervisor has been retained by the Plan Administrator to manage the Plan. The Plan Supervisor is contemplated to be a Party in Interest, as defined by ERISA.

## Named Fiduciary and Plan Administrator

The Named Fiduciary and *Plan Administrator* is set forth in the Schedule of Terms and Benefits. The Plan Administrator shall have the sole and final authority to control, manage and determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained.

The named Plan Administrator may delegate responsibilities for the operation and administration of the Plan to the Plan Supervisor.

The Plan Administrator shall nominate a person or persons, referred to in the Schedule of Terms and Benefits as the *Plan Coordinator* to assist in day-to-day Plan matters. The Plan Administrator shall have the authority to amend the Plan and to determine its policies, to appoint Plan Supervisors, fix their compensation (if any), and exercise general administrative authority over them. Copies of amendments for any material reduction in covered services or benefits will be furnished to the Participants no later than sixty (60) days after the adoption of the changes. The Plan Administrator has the sole authority and responsibility to review and make final decisions on Plan matters such as benefit adjudication, eligibility for coverage determinations and construing terms.

The Plan Administrator shall, in its sole discretion, interpret all Plan Provisions, and make all determinations as to whether any particular Covered Person is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review.

If any eligible Employee who performs services for this Employer that are or may be compensated for in part by benefits payable pursuant to this Plan, such an Employee shall be treated as agreeing with and consenting to any to any decisions that the Plan Administrator makes, in its sole discretion, and further agrees to the limited standard of review described by this section by the acceptance of such benefits.

## Plan Administration

The Plan document may provide health-care related welfare benefits as defined in ERISA Section 3(1). Such benefits are set forth in the Schedule of Terms Benefits. The benefit administration may be with (i) a contract administrator referred to as the Plan Supervisor or, (ii) the Employer. *The Plan Year* is set forth in the Schedule of Terms and Benefits. The Plan Supervisor will assign an ERISA *Plan Number* and, as needed, a *Plan Number for Administration Purposes*.

Plan Supervisors may be changed and benefits may be changed, added and deleted by Plan amendment. Multiple Schedule A's (insurance statement for ERISA reporting) may be added to the DOL/IRS Form 5500.

Plan assets if any, shall be governed by a trust. The trust is often, but not necessarily, a tax-exempt trust. *Plan Trustees* are set forth in the Schedule of Terms Benefits. With a self-funded arrangement the Plan Administrator has final responsibility for all Plan decisions but the day-to-day ministerial duties are assigned to the Plan Supervisor. To the extent that the Plan Supervisor has the authority to conduct and manage the operation and administration of the Plan, such Plan Supervisor shall be deemed to be a fiduciary.

Significant administrative obligations of the Plan Supervisor, if any, include the following:

1. Recordkeeping and invoicing for fixed costs on a monthly basis.
2. Paying Plan benefits by established guidelines set forth by the Plan Administrator.
3. Preparation of identification cards, summary plan description booklets, Plan documents, administration guides and agreements, etc.
4. Timely and accurate ERISA reports where specifically directed by the Plan Administrator. For reporting purposes, the Plan is the *Type of Welfare Plan* set forth in the Schedule of Benefits.
  - a. Annual Return (DOL/IRS Form 5500 and 5500-C).
  - b. Summary Annual Report.Note: Plan Administrator may elect to have such forms prepared by Plan Supervisor. The Plan Administrator may also have other parties prepare such forms.
5. Providing the Plan Administrator with appropriate records and statistics of the Plan's operation.

## **Plan Funding**

The Employer shall make monthly contributions to the Participant Health Care Trust Account which amounts are shown in the Schedule of Terms and Benefits. Such Defined Contributions are allocated to each Participant's Health Care Trust Account which Account is governed by a Trust. *Description of such Trust is set forth in the schedule of Terms and Benefits.* Such Trust Assets are the property of the Participant and are to be used exclusively for the reimbursement of Covered Expenses as may be directed by the Participant. Such Trust Assets are Plan Assets. The Health Care Trust Account for any Participant will never be negative. At the discretion of the Plan Trustees, changes to the Participant's *Health Care Trust Account* for (a) reasonable trust-related administrative-type expenses and or (b) investment income will be made.

## **Federal Laws and Regulations**

The Plan shall be deemed to be amended to comply with any federally-mandated benefit, participation requirement, or similar.

# DEFINITIONS

## Actively-At-Work

The term *Actively-at-Work*, set forth in the Schedule of Terms and Benefits, is defined by the following outline:

1. An Employee is actively-at-work who:
  - a. Performs for the Employer all the substantial and material duties of a job for personal income, profit or gain.
  - b. Is scheduled to perform, and does in fact perform, on a regular basis the hours per week shown in the definition of *Actively-at-Work* in the Schedule of Terms and Benefits.
  - c. Works on the business of the Employer at a place of business or at assigned place.
2. Proprietors, partners, owners, shareholders, directors or others as may be permitted or required by applicable law, will be considered actively-at-work and may be eligible to become covered under this Plan if both (a) and (b) are met:
  - a. They qualify under Item 1, above.
  - b. Their job duties directly relate to the business of the Employer.
3. An Employee shall be deemed actively-at-work on each day of a regular paid vacation, leave of absence or regular non-working day, provided each Employee was actively-at-work on the last preceding regular work day.

## Code

The term *Code* means the Internal Revenue Code.

## College or University

The term *College* or *University* means an institution listed in the current publication of accredited institutions of higher education, or capable of being listed if such were requested or applied for by the institution.

## Covered Expenses

The term *Covered Expenses* mean, expenses for *medical care* within the meaning of the term *medical care* or *medical expense* as defined in IRC §213 and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining such Participant's tax liability under the Code. However, benefits for Durable Medical Equipment or Devices are not provided. Covered Expenses also include premiums for individual policies providing hospital – medical –surgical benefits so long as such policies are approved in writing by the Plan Administrator.

## Covered Person

The term *Covered Person* means the Participant and any and all covered dependents; *covered dependent* means a covered spouse or child.

## Defined Contribution

The term Defined Contribution means the monthly contribution made by the Employer and placed in the Participant Health Care Trust Account.

## Dependent Child

The term *Dependent Child* means a Participant's child who meets all of the following conditions:

1. Is a resident of the same country in which the Participant resides.
2. Is a natural child; a stepchild; a legally adopted child [final adoption before attaining age eighteen (18) and a child who is *placed for adoption* before attaining age eighteen (18)], or a foster child. The child must be principally dependent upon the Participant for financial support and a child for whom the Participant has legal responsibility to support. A child will be presumed to be a dependent if such child is claimed as a dependent for federal income tax purposes. Further proof also may be required that the Participant is legally responsible for the child's health care.

The term *placed for adoption* means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

1. Is unmarried.
2. Is less than the *Unmarried Child's Eligibility Age* as shown in the Schedule of Terms and Benefits; or less than the extended age, shown in the Schedule of Terms and Benefits (if one is provided), if a full-time student in an accredited school, college or university as listed in the most recent edition of *The Directory of Higher Education*.

Dependent status for a child will not be approved, and the dependent coverage, previously approved, will cease for any of the following reasons:

1. Upon the date such child is employed full-time for wages, profit, or gain;
2. Upon the date such child becomes eligible for coverage under this Plan as an Employee;
3. Upon the date such child is on active duty in the military forces of any government for more than thirty (30) consecutive days.

Dependent status, once lost, may be reacquired under this definition in the following manner: for dependent children who are not covered by the Plan because either:

1. They were previously covered under the Plan and lost coverage because they exceeded the eligibility age and did not remain in school; or
2. They were already over the eligibility age when coverage was first available:

Such dependent children may become covered under the Plan if they become full-time students before reaching the extended eligibility age set out in the Schedule of Terms and Benefits (if the Plan provides for an extended eligibility age). The effective date of coverage for any such dependents who reacquire dependent status shall be the first day of the next month after the day they become full-time students.

In those situations where a Dependent Child was not enrolled when first eligible, is now over the Unmarried Child's Eligibility Age but is still younger than the extended eligibility age (if any) provided in the Schedule of Terms and Benefits, such child may be enrolled in the Plan if he or she becomes a full time student and if the Plan allows *Late Enrollment*.

### **Effective Date of Coverage**

The term *Effective Date of Coverage* shall mean the date coverage is effective with respect to a Covered Person.

### **Election Period**

The term *Election Period* means the period preceding the beginning of each Plan Year, after the Plan Year, as set forth in the Schedule of Terms and Benefits.

### **Eligibility Waiting Period**

The term *Eligibility Waiting Period* shall mean that period from the Enrollment Date until the first day that coverage is provided by the Plan.

### **Employee**

The term *Employee*, as set forth in the Schedule of Terms and Benefits, means any employee of the Employer and, if the Employer is a partnership, any natural-person partner of the Employer. For the purposes of this Plan, former employees and retirees of the Employer may be eligible for coverage, if so designated by the Employer as *Eligibility Class* as set forth in the Schedule of Terms and Benefits. Unless otherwise indicated in the Schedule of Terms and Benefits, part-time and seasonal employees are not covered.

### **Enrollment Date**

The term *Enrollment Date* means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

## **ERISA**

The term *ERISA* means the Employee Retirement Income Security Act of 1974, as from time to time amended and clarifying regulations. The type of plan for ERISA purposes is shown as *Type of Welfare Plan* in the Schedule of Terms and Benefits.

## **Foster Child**

The term *Foster Child* means a child whose care, comfort, education and upbringing has been left to persons other than his or her natural parents as evidenced by sufficient documentation as determined by the Plan Administrator or the Plan Supervisor.

## **Full-Time**

The term *Full-Time* means a basis of employment which requires the employee to be at work, or to be scheduled for work, for at least the *Qualifying Hours*, as set forth in the Schedule of Benefits. Such hours are to be worked either at the usual place of business of the Employer or at a location to which the business of the Employer requires the employee to work or travel, and for which regular earnings are received from the Employer.

## **Incurred**

The term *Incurred* means the receipt of goods or services for which an obligation to pay arises. The incurred date is the date on which services are rendered or goods are provided, creating the obligation to pay the provider of such goods or services.

## **Late Enrollee**

The term *Late Enrollee* means a person who fails for any reason to enroll for coverage other than on the earliest date on which coverage can be effective.

## **Participant**

The term *Participant* means an Employee who is eligible for coverage, elects to be covered and is enrolled (becomes covered).

## **Participant Contributions**

The term *Participant Contributions* mean those deductions taken from a Participant's earning either as a payroll deduction or by means of a salary reduction plan.

**Participant Contributions** are required as a condition to a Participant's eligibility to this Plan. Such contributions must be applied as follows:

### **Option Number 1**

As contributions to an Employer-maintained, high deductible, group plan.

### **Option Number 2**

As contributions to a Flexible Spending Account.

## **Participant Health Care Trust Account**

The term Participant Health Care Trust Account is the account dedicated to the Participant and governed by a Trust. It will never be negative. It is the balance between the Defined Contributions made by the Employer and the Withdrawals for Plan Benefits.

## **Participating Employer**

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

## **Plan Supervisor**

The term *Plan Supervisor* means the administrative firm retained by the Employer to supervise and manage the Plan performing such duties as recordkeeping, claims processing, consulting, general monitoring and overseeing, etc.

## **Spouse**

The term *Spouse* means the wife or husband of the Participant, not legally separated or divorced from the Participant.

# ELIGIBILITY

## New Employee Eligibility

Employee is one who meets such requirement as shown in the Schedule of Terms and Benefits. Persons eligible for coverage under this Plan shall include only those persons who meet all of the following conditions:

1. Employed by the Employer on a regular full-time basis for at least the Qualifying Hours per week as set forth in the Schedule of Terms and Benefits.
2. Actively-at-work at the assigned place of employment and in performance of the assigned duties. Actively-at-work is set forth in the Schedule of Terms and Benefits.
3. Member of an Eligibility Class as set forth in the Schedule of Terms and Benefits.
4. Fulfill the Eligibility Waiting Period as set forth in the Schedule of Terms and Benefits.

For the date of eligibility, see Eligibility Waiting Period in the Schedule of Terms and Benefits. If application is made after the date of eligibility by less than thirty (30) days for contributory coverage or one hundred eighty (180) days for non-contributory coverage, such coverage shall be effective on the date of eligibility.

An Employee who fails to apply on a timely basis will be a Late Enrollee and eligible to participant on the next Subsequent Annual Election.

## Effective Date of Enrollment

Enrollment is effective not later than the first day of the first month beginning after the date the completed request for enrollment is received. This is the *Effective Date of Coverage* for such participant.

## Other Employee Eligibility

Each Employee in an eligible class, who was covered under the Plan replaced by this Plan, shall become enrolled (covered) for Employee coverage on the Effective Date of this Plan. Each Employee in an eligible class whose *Eligibility Waiting Period* began, but was not completed, under the Plan replaced by this Plan will become enrolled (covered) on the date such waiting period is completed. Unless otherwise indicated herein, retired former participants are not eligible for coverage.

## Participant Termination Date

1. The coverage of any Participant shall cease at the earliest time indicated below except as provided in the Extended Coverage Provisions:
  - a. Date of termination of employment.
  - b. Date Participant ceases to be in a class of employees eligible for coverage (including being not actively-at-work and not performing regular duties).
  - c. Date Participant fails to make required contributions for coverage.
  - d. Date Plan is terminated.
  - e. Date Employer terminates Participant's coverage.
  - f. Date Participant dies.
2. For a previously covered Employee who is rehired in an eligible class by the Employer within the *Re-employment Period*, if any, set forth in the Schedule of Terms and Benefits, and who has returned to actively-at-work, full-time service, the date of eligibility shall be the first day of the next month following the date of re-hire. Any dependents who were covered on the date the Employee left the Employer shall become eligible and can be enrolled (covered) on the eligibility date of such rehired employee.

If the rehired Employee applies for coverage within thirty (30) days of the rehire date, the Employee (and any dependents who were covered on the date the Employee left the Employer) shall not be *Late Enrollees*.

Any dependents who were not covered on the date the Employee left the Employer may be enrolled when the employee is rehired but the Eligibility Waiting Period set out in the Schedule of Terms and Benefits shall apply.

## Dependent Initial Eligibility Date

1. A spouse and unmarried child whose age is less than the *Unmarried Child's Eligibility Age* as shown in the Schedule of Terms and Benefits are eligible for coverage. Physically handicapped or mentally retarded dependent children, regardless of age, will be covered upon presentation of proof of condition, as set forth in the Schedule of Terms and Benefits, and as long as family coverage is maintained. To be eligible for coverage, a physically handicapped or mentally retarded child must be unmarried, incapable of self-support because of condition, and principally dependent upon the Participant for financial support. Proof of condition may be required once each year.
2. Coverage for a dependent will be effective on the date the Employee is enrolled (covered) if the Employee applies for coverage for the dependent when the Employee joins the Plan

3. **Special Enrollment Rules for Newly Acquired Dependents** – If an Employee without a dependent on the date the Employee becomes eligible for coverage, later acquires a dependent or dependents as a result of marriage, birth, adoption, placement for adoption, or obtaining custody of a foster child, such Employee, if not already a Participant; and the new dependents will be allowed to enroll (become covered) in the Plan, provided that written application for coverage is made within thirty (30) days after the acquisition date, (date of marriage, birth, adoption, placement for adoption, or obtaining custody of a foster child).

Such thirty (30) day period is extended to one hundred eighty (180) days for a dependent child where the addition of such child does not affect the Participant's contribution to the Plan.

4. **Effective Date of Coverage – Timely Application**
  - a. **Marriage** – *The Effective Date of Coverage* shall be the date of marriage.
  - b. **Birth** – *The Effective Date of Coverage* shall be the date of birth of the child.
  - c. **Adoption or Placed for Adoption** – *The Effective Date of Coverage* shall be the earlier of the date of adoption or placement for adoption. This includes a child born of a surrogate mother.
  - d. **Foster Child** – *The Effective Date of Coverage* shall be the first day of the first calendar month beginning after the date sufficient evidence has been received to determine that the child is an eligible dependent but no earlier than the date the Employee obtained custody of the child.

If the Effective Date of Coverage, as set forth above in (a) through (d), is earlier than the Employee's completion of the Eligibility Waiting Period, the Effective Date of coverage will be the date the Employee has met any applicable waiting period under the Plan provided the Employee is eligible to be enrolled (covered) under the Plan but for a failure to enroll during a previous enrollment period.

5. If the coverage for a dependent is applied for more than thirty (30) days following the date that the dependent becomes eligible for coverage, such dependent will be considered as a *Late Enrollee* subject to a postcoverage waiting period of eighteen (18) months for preexisting conditions.

## **Dependent Termination Date**

The coverage of any covered dependent shall automatically cease at the earliest time indicated below, except as provided in the Extended Coverage Provisions:

1. Date of termination of Participant's employment.
2. Date Participant ceased to be in a class of employees eligible for coverage.
3. Date Participant fails to make any required contribution.
4. Date Plan is terminated.
5. Date Employer terminates Participant's coverage.
6. Date Participant dies.
7. Date dependent loses eligibility status as provided herein.

## **Participant Elections**

### **Initial Election**

Upon initial enrollment, an Employee may elect to participate in this Defined Contribution Plan or a companion Defined Benefit Plan if such is also offered by the Employer. There is reasonable economic parity between the two plans:

#### **Defined Contribution Plan**

This Plan is designed for those Employees primarily wishing to protect their income, and who wish to gain virtual control as to how their Employer contribution may be used and permit budgeting of such Employer contributions for their future medical care needs.

#### **Defined Benefit Plan**

This Plan is designed for those Employees primarily wishing to protect their assets, giving up access to first dollar coverage in exchange for catastrophic type medical benefits.

## Changing Election

During the Election Period, as set forth in the Schedule of Benefits, prior to each subsequent Plan Year, each Participant will be given the opportunity to change elections. Any such election shall be effective for any Benefit expenses incurred during the Plan Year that follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

- A Participant, or Employee who declined to initially elect to participate, may elect different or new Benefits under the Plan during the Election Period.
- A Participant may terminate participation in the Plan either by notifying the Plan Administrator in writing during the Election Period that such person does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options.
- An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan unless such person experiences a change in family status or other event that permits a change of election during the Plan Year.
- Any Participant failing to complete an election of benefits form by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year.

## Covered Dependents

Dependents of the Participant are eligible to be Covered Dependents. In operation, the Participant Health Care Trust Account with a single Participant and one with a Participant and one or more Covered Dependents function the same. The Participant will be the decision-maker during that time when there are no family changes, (death, divorce, separation, e.g.).

No distinction is made between medical expenses, covered expenses or Plan Benefits which are attributable to a Participant or to a covered Dependent.

Should there be family changes (death, separation, divorce, e.g.) these rules will be followed:

<u>Priority</u>	<u>Rule</u>
1	As directed by the Participant and spouse (including one
2	separated or divorced) jointly.
3	As provided by legal papers provided to the Plan Administrator.
4	As deemed reasonable by the Plan Administrator.

Trust assets will be divided and placed in multiple Trust Accounts so as to reflect the application of the Rules shown above. No cash distributions may result from a family change except as may be provided by the *de minimis* Rule. A Covered Dependent, who as the result of a family change, has a Trust Account in such Dependent's name, is to be recognized as the Participant for purposes of the Trust Account.

# **PLAN BENEFITS**

## **Defined Contributions**

The Schedule of Terms and Benefits specifies the amount of monthly Defined Contributions which will be made by the Employer for each Participant.

## **Participant Contributions**

The Schedule of Terms and Benefits sets forth whether or not Participants Contributions are required also, if such contributions are required the manner by which such contribution shall be treated.

## **Paying Plan Benefits**

All medical expenses which are incurred while a Participant or covered dependent are Plan Benefits. Documentation must be provided to the Plan Supervisor that the submitted medical expenses are eligible Plan Benefits. Plan Benefits may be paid either to the Participant or to a provider-assignee.

# ADMINISTRATION

## General

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

- (a) To make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plan.
- (b) To interpret the Plan; the Plan Administrator's interpretations thereof in good faith shall be final and conclusive on all persons claiming benefits by operation of the Plan.
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan.
- (d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of any applicable laws and regulations.
- (e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan.
- (f) To approve reimbursement requests and to authorize the payment of benefits;
- (g) To appoint a Plan Supervisor or other professionals as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation, or construction taken by the Plan Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with all applicable laws and regulations.

## Plan Records

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

## **Administrative Expenses**

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Plan Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated participants.

## **Indemnification of Plan Administrator**

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

# ERISA PROVISIONS

## Claim for Plan Benefits

All claims for Plan Benefits shall be made to the Plan Supervisor in accordance with the Plan's claims processing rules.

At no time will a claim be *funded* (i.e., paid) where such funding (i.e., payment) would cause the Participant Health Care Trust Account to be negative.

The Benefit Processing Responsibility of the Plan Supervisor is specified in the Schedule of Term and Benefits.

## General Fiduciary Responsibilities

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

- (a) For the exclusive purpose of providing Benefits to such covered persons and defraying reasonable expenses of administering the Plan.
- (b) With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.
- (c) In accordance with the documents and instruments governing the Plan providing such documents and instruments are consistent with ERISA.

## Medical Privacy and Confidentiality

All relevant medical privacy and confidentiality rules promulgated by federal or state laws or regulations will be followed.

## Anti-Discrimination

The Plan will at all times follow all relevant anti-discrimination rules promulgated by federal or state laws or regulations. Specifically:

1. Plan Benefits (including eligibility therefore) and Plan contributions will not directly or indirectly favor the so-called *prohibited* (i.e., highly compensated or key employee) group.
2. Plan Benefits (including eligibility therefore) and plan contributions will not directly or indirectly harm the so-called *protected* group (age, sex, race, national origin and health status).

# MISCELLANEOUS

## Amendment

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with all applicable laws and regulations.

## Termination of Plan

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any individual insurance policy or any other contract shall be paid in accordance with the terms of such policy or contract.

In the event the Plan is terminated, no further additions shall be made to the Participant Health Care Trust Account, but reimbursements for claims incurred during the Plan Year but prior to the termination date shall continue to be made according to the elections in effect at the time of the Plan's termination for a reasonable period of time but not less than the Claim Filing Period set forth in the Schedule of Terms and benefits. Any amounts remaining in any such fund or account as of the end of the Plan Year in which Plan termination occurs shall be forfeited and deposited in the benefit plan surplus after the expiration of the Claims Filing Period.

## Plan Interpretation

Plan provisions shall be interpreted in a non-discriminatory manner. This Plan document and its attachments, if any, constitute a written document as required by laws and regulations.

## Participant Rights

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or Employee nor to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon such person as a Participant of this Plan.

## Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or covered dependent under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply or be available to any Participant. It shall be

the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

## **Notices**

Any notice, application, instruction, designation or other form of communication required to be given to or submitted by any Participant or beneficiary shall be in such form as is prescribed from time to time by the Plan Administrator and shall be sent by first class mail or delivered in person to the Plan Administrator of the Plan. Any notice, statement, report or other communication from the Plan Administrator to any covered person shall be deemed to have been duly delivered when given to such person or mailed first class to such person at the Participant's address last appearing on the records of the Plan Supervisor or the Plan Administrator. Each person entitled to receive a payment under the Plan shall file in accordance herewith the person's complete mailing address and any change thereof. If the Plan Administrator shall be in doubt as to whether payments are being received by the person entitled thereto, the Plan Administrator may, by registered mail addressed to such person's address last known to the Plan Administrator, notify such person that all future payments will be withheld until such person submits to the Plan Administrator the proper mailing address and such other information the Plan Administrator may reasonably request.

## **Free Choice of Physician**

The covered person shall have free choice of any physician or surgeon. The physician-patient relationship shall be maintained.

## **Misstatements**

In the event of any misstatement of any fact(s) affecting coverage under the Plan, the true facts will be used to determine the proper coverage. Coverage means eligibility as well as the amount of any benefits thereunder. Any intentional misstatement of material and relevant facts by, or on behalf of, a Participant may result in enrollment being voided and/or denial of benefits.

## **Plan Amendments**

This Plan document contains all the terms of the Plan and may be amended from time to time by the Plan Administrator or Employer through its Board of Directors, officers, or designated management representatives. Such Plan Amendments shall be prepared in writing and attached to, and made part of, this Plan document. Such Plan Amendment shall indicate both the effective date of the change to the Plan, as well as the execution date of the Plan amendment. The authority for the Plan Amendment procedure is with the Plan Administrator or its duly designated persons. Such Plan Amendments shall, to the extent the benefits and terms of conditions for eligibility on benefits affect a Plan Participant, be communicated, in writing, to such Plan Participant. Any changes so made shall be binding on each Participant and on any other covered person referred to in this Plan document.

# STATEMENT OF ERISA RIGHTS

## Certain ERISA Requirements

This Summary Plan Description has been prepared to furnish you, the Participant, with information regarding the benefits to which you and your eligible dependents may be entitled under this Plan. The Employee Retirement Income Security Act of 1974 (ERISA) requires that all Participants be furnished a Summary Plan Description (SPD/Booklet) of their benefit plan.

The Schedule of Benefits in this booklet gives you this information and details about the benefits of your Plan. The objective of this booklet is to describe the Plan clearly and directly; however, if you have any questions concerning the Plan or the information and provisions of the Summary Plan Description, please consult your Plan Supervisor.

The Schedule of Benefits identifies the Plan name, Effective Date of the Plan, Type of Welfare Plan, Plan Year, the Plan Administrator, the Plan Supervisor, the Plan Trustees, if any, the Plan Coordinator and the required Plan Numbers. The employer shown in the Benefit Schedule is also the Plan Sponsor. Benefits on behalf of named Participating Employers may also be provided through the Plan.

## Statement of Rights

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, if such report is required.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if required, and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report, if the plan is required to prepare such a report. Some plans, such as plans with fewer than one hundred (100) participants may not be required to prepare a summary annual report.

- Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan and the rules governing your COBRA continuation coverage rights.
- Reduction of elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for twelve (12) months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called *fiduciaries* of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within thirty (30) days, you may file suit in a Federal Court.

In such a case, the Court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal Court. In addition, if you disagree with the plan's or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The Court will decide who should pay Court costs legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

## Appeals Procedures

If your claim should be denied in whole or in part, you will receive written notification delivered in the same fashion as a reimbursement of a claim. A claim worksheet or Explanation of Benefit (EOB) will be provided by the Plan Supervisor showing the calculation of the total amount payable, charges not payable, and the reason. If you do not understand the reason for any unreimbursed amount or disagree with the adjudication, call the Plan Supervisor.

If your claim should be denied and the benefit is significant, you will be given a written formal denial letter stating clearly and precisely why the claim was denied and action that may be taken on your part to have the claim reviewed for possible payment. If you believe the claim was denied in error, you should respond to the formal denial letter with a request for a review by the Plan Supervisor. Upon this written request, which must be filed within sixty (60) days after the denial, the Plan Supervisor will review the claim in question and give a written decision of the review within sixty (60) days after such request is received [or within one hundred twenty (120) days under special circumstances]. You may also use this procedure to appeal any determination that has been made under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding your prior creditable coverage. Legal action against the Plan is possible; however, it must be filed during a given period. That period is from sixty (60) days to three (3) years from date proof of loss is filed. You should not file legal action against your Plan until you have gone through the appeal procedure described above.

## Other Items of Interest

You receive no special employment rights from this Plan. The Employer shall have the sole and final authority to control, manage and determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. The named Plan Administrator may delegate responsibilities for the operation and administration of the Plan to the Plan supervisor. The Plan Administrator shall nominate a person or persons, referred to in the Schedule of Benefits as the *Plan Coordinator* to assist in day-to-day Plan matters. The Plan Administrator shall have the authority to amend the Plan and to determine its policies, to appoint Plan supervisors, fix their compensation (if any), and exercise general administrative authority over them. Copies of amendments for any material reduction in covered services or benefits will be furnished to the Plan Participant no later than sixty (60) days after the adoption of the changes. The Plan Administrator has the sole authority and responsibility to review and make final decisions on Plan matters such as benefit adjudication, eligibility for coverage determinations and construing terms. Further, the Plan Administrator will, in its sole discretion, have complete authority to determine the validity and acceptability of Certificates of Creditable Coverage.

All Certificates of Creditable Coverage accepted by the Plan Administrator will be honored by this Plan for the purpose of satisfying this Plan's Preexisting Condition provisions, provided however that a Certificate of Creditable Coverage which is subsequently determined to be inaccurate, erroneous or fraudulently obtained or prepared shall be disregarded.

The Plan Administrator shall, in its sole discretion, interpret all Plan provisions and make all determinations as to whether any particular Covered Person is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. If any eligible Employee who performs services for this Employer that are or may be compensated for in part by benefits payable pursuant to this Plan, such an Employee shall be treated as agreeing with and consenting to any decisions that the Plan Administrator makes, in its sole discretion, and further agrees to the limited standard of review described by this section by the acceptance of such benefits.