Venice Christian School

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) Plan

Plan Document
&
Summary Plan Description

Plan Administered By:

Preferred
BENEFIT ADMINISTRATORS
INCORPORATED

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR
VENICE CHRISTIAN SCHOOL QSEHRA PLAN

Effective August 1, 2018

INTRODUCTION

This document is a description of Venice Christian School Qualified Small Employer Health Reimbursement Arrangement (the Plan). The Plan described is designed to provide eligible employees of Venice Christian School with the opportunity to receive reimbursement for certain health care expenses.

The Plan is intended to qualify as a "Qualified Small Employer Health Reimbursement Arrangement" within the meaning of the 21st Century Cures Act and Section 9831(d) of the Code. Benefits provided under the Plan shall be eligible for exclusion from each Employee's income for federal income tax purposes if all requirements applicable to a QSEHRA are met. The provisions of this Plan shall be interpreted in accordance with that intent.

This Plan is funded solely by the Employer and reimburses individual health insurance policy premiums of an Employee and Dependents up to a maximum amount established by the Employer or as required by law. The Plan is offered as a means for reimbursing employees for the purchase of individual health insurance coverage. A Participant must be enrolled in the Plan as a condition of participation in this Plan.

The Plan will pay benefits only for expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage is terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

Venice Christian School employs fewer than 50 full-time equivalent Employees and does not offer group health insurance to any of its Employees. This Plan is not a group health plan and is not subject to any health care continuation rights.

Venice Christian School may amend or terminate the Plan at any time and will provide notice to all Participants.

If the Plan is terminated, the rights of covered Participants shall be limited to covered charges incurred before the date of termination.

Keep this document in a safe place for future use and reference. The Plan contains provisions, limitations and exclusions that could result in disqualifications, ineligibility, denial or loss of Benefits.

Any questions about Coverage should be directed to:

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188

(407) 786-2777 or (888) 524-2777

Venice Christian School will provide an annual written notice to Eligible Employees no later than 90 days before the beginning of the Plan Year (or if an employee is not eligible to participate in the Plan as of the beginning of the Plan Year, the date on which the Eligible Employee is first eligible to participate in the Plan). The notice will contain the information required by Code section 9831(d), including the amount of the permitted benefit under the Plan, a statement indicating the Eligible Employee should provide information regarding the amount of the benefit to any health insurance exchange to which the employee applies for advance payment of a premium tax credit and any reimbursement under the Plan may be includible in gross income.

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I. PLAN NAME

The name of the Plan is the Venice Christian School QSE Health Reimbursement Arrangement (HRA) Plan. In this Plan Document and Summary Plan Description it will be referred to as the "Plan".

II. PLAN IDENTIFICATION NUMBER

The Employer identification number (EIN) assigned by the Internal Revenue Service is 59-2834505. The Group number assigned by the Claims Administrator is 440-QSEHRA.

III. PLAN ADMINISTRATOR AND HEADQUARTERS

Venice Christian School
1200 Center Road
Venice, FL 34292
(941) 496-4411

IV. PLAN YEAR

The QSEHRA Plan year is from August 1st of each Calendar Year through July 31st of the next Calendar Year.

V. PLAN SPONSOR

Venice Christian School established and sponsors the Plan.

VI. LEGAL PROCESS

Legal process may be served on Venice Christian School, QSEHRA Plan Administrator, at the address shown above.

VII. PLAN CONTRIBUTIONS

QSEHRA Plan contributions are made by Venice Christian School.

VIII. PLAN TYPE AND ADMINISTRATION

The Claim Administrator administers QSEHRA claims for benefits pursuant to a contract with the Plan Administrator.

IX. CLAIMS ADMINISTRATOR

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188
(407) 786-2777 or (888) 524-2777

X. DEFINITIONS

The following definitions have distinctive meanings and when used in this Plan will be capitalized.

A. "**Administrative Functions**" mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan. Administrative Functions include quality assurance, employee assistance, claims processing, auditing, and monitoring. PHI for these purposes may not be used by or between the Plan or Business Associates in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Administrative Functions specifically do not include any employment-related functions.

B. "**Calendar Year**" means the period of twelve (12) consecutive months commencing at 12:00 a.m. on January 1 and ending at 12:00 midnight on December 31 of a given year. For Participants enrolling during a Calendar Year, the "Calendar Year" begins on the effective date of their Coverage and ends on December 31 of that same year.

C. "**Claims Administrator**" means Preferred Benefit Administrators, Inc. or any Successor Corporation or entity.

D. "**Dependent**" means an individual who is a spouse of an Employee or a dependent, as defined in Section 152 of the Code, determined without regard to Section 152(b)(1), (b)(2), and (d)(1)(B) of the Code, of an Employee. Further, the term "Dependent" also includes an Employee's child as defined under Code Section 152(f)(1) who has not attained age 27 as of the end of the calendar year, as

provided by Code Section 105(b), as amended by the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010.

E. "**Employee**" means a person who is an active, regular Employee of the Employer working on average 37.5 hours per week, who is not covered through a group health plan sponsored by the Employer.

F. "**Employer**" means Venice Christian School and any subsidiaries, as defined in the Claims Administration Contract creating the Health Benefit Plan.

G. "**Employment Waiting Period**" This Plan does not have an Employment Waiting Period, therefore QSEHRA benefits begin on the first day of full-time employment with the Employer.

H. "**ERISA**" is the Employee Retirement Income Security Act of 1974, as amended.

I. "**QSEHRA**" means a Qualified Small Employer Health Reimbursement Arrangement as defined in IRS Notice 2002-45. This type of HRA account is established by the Employer for each eligible Employee. Employer contributions are deposited, to be used to reimburse the Plan Participants for legitimate and approved health care expenses. Any amounts remaining in the QSEHRA Account at the end of the Plan Year will be forfeited.

J. "**HIPAA**" means Health Insurance Portability & Accountability Act of 1996.

K. "**Open Enrollment Period**" means the one-month period prior to the beginning of each Plan year in which a Late Entrant may access the Plan upon completion of an enrollment application.

L. "**Participant**" means and includes the Employee and any of his or her legal Dependents covered under this Plan. Participant also means a Late Entrant and Special Enrollee. Any Employee retiring shall not be eligible to participate in the Plan and shall not be a Participant.

Participant also means and includes those Employees who qualify for and take leave under the Family Medical Leave Act of 1993.

The term Participant does not include nonresident alien employees with no U.S. source of income, employees covered under a collective bargaining agreement that does not provide for coverage under this Plan, and any employee who performs service for the Employer as a leased employee within the meaning of Code section 414(n) or 414(o).

M. "**Plan**" means this Plan Document and Summary Plan Description including any Schedule of Benefits and Amendments attached hereto.

N. "**Plan Administrator**" means Venice Christian School, unless a person or committee of persons is designated by the Employer to administer the Plan on behalf of the Employer.

XI. ELIGIBILITY, ENROLLMENT AND COVERAGE EFFECTIVE DATE

A. Eligible Employees of the Employer will be enrolled in the QSEHRA upon being hired as a full-time Employee.

B. If an Employee meets the definition of Employee in this Plan, HRA Benefits will become effective immediately.

C. If a Participant terminates employment with the Employer for any reason, and then is re-hired within thirty days or less following the date of such termination of employment, the Participant will be reinstated with the same QSEHRA balance that the Participant had prior to the termination.

XII. TERMINATION OF COVERAGE

Important Notice: If an Employee no longer meets the eligibility requirements of the Plan, the Employee is responsible for notifying the Employer or Claims Administrator of the change in status. Coverage will not continue beyond the last date of eligibility even if notice has not been given to the Employer or Claims Administrator.

Coverage will terminate upon the earliest of the following dates:

A. Coverage will terminate on the last day of the month in which employment terminates.

B. The date on which the participant goes on a leave of absence, is laid off, or is, on a regular basis, actively at work in employment by the employer for less than the number of hours per week required to be initially eligible for coverage. However, a participant taking a qualified leave under the Family and Medical Leave Act of 1993 shall not cause health coverage to end to the extent required by the FMLA.

C. The date on which the participant ceases to be in a classification (if any) in the Eligibility and Participation section for coverage.

D. The date on which the plan is terminated.

E. The date on which the plan administrator terminates the participant's coverage for cause, which includes a termination for fraud or misrepresentation in an application for enrollment or in a claim for benefits.

F. The effective date of the participant's notice of voluntary withdrawal.

G. The date of the participant's death.

If a Participant ceases participation in the QSEHRA during the Plan Year or as of the end of a Plan Year, the Participant shall be eligible to be reimbursed only for Qualifying HRA Expenses incurred while the individual was a Participant in the Plan. Expenses incurred after participation terminates shall not be eligible for reimbursement. Any amounts remaining in the Participant's HRA Account shall be forfeited and the Participant shall not be eligible for any rollovers.

XIII. QUALIFIED HRA EXPENSES

The benefits available under this Plan for a Plan Year shall take the form of reimbursements for health care expenses during the period of Coverage. A Participant shall be entitled to reimbursement under this Plan only for health care expenses after participation has commenced and before participation has ceased.

The Employer shall bear the entire expense of providing the benefits set forth in this Plan. All payments shall be made from the HRA established in each employee's name. The employee may not contribute to the HRA.

Each Participant is entitled to receive reimbursement of eligible expenses when requested, while the Plan is in force.

A. **Qualified HRA Expenses** mean expenses incurred by a Participant or one of the Participant's Dependents that satisfy **all** of the following requirements:

The expenses incurred are for the medical care of the Participant or one of the Participant's Dependents and such expenses were paid by the Participant and not by any other health plan.

The expenses are not eligible to be paid or reimbursed by any other plan or insurance or any other source.

The expenses were incurred while the applicable individual was covered by this HRA Plan.

HRA Expenses means any amount incurred by a Participant, Dependent, and Spouse that is an expense for individual health insurance policy premiums reimbursable under section 213(d) of the Code, excluding expenses reimbursed by any other health care plan. The Claims Administrator shall determine whether any amount constitutes a Health Care Expense that qualifies for reimbursement hereunder.

In order for the Plan to reimburse individual health insurance policy premiums tax-free, the individual policy must offer minimum essential coverage as defined by the Affordable Care Act. Documentation of individual health insurance coverage must be submitted to the Claims Administrator.

B. **Establishing and Crediting of HRA Account**

The Employer will establish an HRA Account in the Participant's name and credit a monthly pre-determined amount to the HRA Account on behalf of each eligible Participant.

The Employer may establish rules, in addition to those already prescribed hereunder, for the timeliness of contributions to be made into each employee's HRA Account.

A Participant's HRA Account cannot have unused balances transferred or rolled over to the next Plan Year. This is a "use it or lose it" account – all amounts remaining in the account at the end of the Plan Year (after all reimbursements for eligible Health Care Expenses have been made) will be forfeited by the Participant.

All contributions and limitations on reimbursement shall be prorated to reflect participation during a period shorter than the entire Plan Year.

For individuals who are Participants on the first day of the Plan Year, or become a covered Participant at anytime during the Plan Year, the amount of the HRA credit shall be as follows:

- **$150 per month** for a Participant enrolled for in the QSEHRA Plan.

The Employer may change its credit amount for a subsequent Calendar Year. The Employer shall notify Participants of any change in the credit amount for a subsequent Calendar Year. By law, Participants may not make contributions to their HRA Accounts.

C. Reimbursement of Qualified HRA Expenses

The amount credited to the Participant's HRA Account may be reimbursed to the Participant for Qualifying HRA Expenses. For each Plan Year, the Participant may apply for the reimbursement of Qualifying HRA Expenses to the extent of the Employer's credit for the Calendar Year.

D. Impact on Premium Tax Credits

A reimbursement paid under this Plan will reduce the amount of premium tax credits received from a federal or state marketplace.

E. Rollover of HRA Balances

This HRA Plan does not contain a rollover provision. Any HRA funds remaining at the end of each Plan Year will be forfeited.

XIV. SUBMITTING A CLAIM FOR REIMBURSEMENT

To be entitled to reimbursement under this Plan, a Participant must comply with the rules the Claim Administrator has established for claiming benefits, including, without limitation, the completion and filing of a written application and providing required documentation.

Claimants shall submit a claim for HRA reimbursement to the Claim Administrator along with an HRA reimbursement request form within in 90 days of incurring the eligible expense. The Claim Administrator shall evaluate the claim and notify the claimant of the approval or disapproval, in accordance with the provisions of the Plan.

A. Any claimant whose claim for reimbursement under the Plan is denied, in whole or in part, shall be given notice of the denial within 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Claims Administrator both determines that such an extension is necessary owing to matters beyond the control of the Claims Administrator and notifies the claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary owing to the failure of the claimant to submit the information required to decide the claim, the notice of extension shall describe the information still needed, and the claimant shall be granted 45 days from the receipt of the notice to provide the additional information. The Plan's period for making the benefit determination shall be the 15-day period beginning on the date the claimant furnishes the additional information. If the claimant does not provide the additional information within 45 days from the receipt of the extension notice, the Claims Plan Administrator may issue a denial of the claim within 15 days after the end of the 45-day period.

B. Once an HRA claim for reimbursement is approved, payment shall be made as soon as administratively feasible.

C. Always keep a copy of all records and send all HRA claim reimbursement requests to:

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188

Fax: (407) 786-2999 Email: Claims@PreferredTPA.com

D. If a claim is denied in whole or in part, the Claims Administrator shall provide the claimant with a written or electronic notification of the denial. The notice shall set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, and describe any additional material or information necessary for the claimant to perfect the claim. The notice shall also describe the Plan's review procedures and related time limits and will include a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review. If the denial was based upon an internal rule, guideline, protocol, or other similar criterion, a copy shall be provided free of charge to the claimant upon request.

XV. WHEN CLAIMS SHOULD BE FILED

Claims for HRA reimbursement must be filed with the Claim Administrator. Qualifying HRA Expenses incurred during a Calendar Year may be reimbursed if the claim is submitted during that Plan Year or no later than **90 days** following the last day of the Plan Year. Claims shall be paid as soon as administratively feasible. The Participant shall request reimbursement pursuant to the procedures established by the Claim Administrator. The Claim Administrator shall verify each claim for reimbursement and determine whether the claim is for expenses covered by the Plan. All reimbursement checks shall be made payable to the Participant. The Plan shall not recognize an assignment of HRA benefits. Claims for reimbursement of Qualifying HRA Expenses shall be treated as post-service claims and shall be subject to the claim and appeal procedure provisions of the Claim for Reimbursement and Review of Claim Denial sections.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the HRA claim. If not, more information may be requested.

Note: The Employer has no responsibility to fund HRA claims that are submitted after the above filing deadline.

XVI. Special Rules for Non-Grandfathered Plans

This Plan is not a grandfathered plan under Health Care Reform. Accordingly, Participants must be provided with the following additional rights with respect to claims and appeals:

A. A claimant has the right to appeal an adverse benefit determination under the Plan, which includes a denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan.

B. In connection with the appeal of an adverse benefit determination, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale for the adverse benefit determination. Further, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

C. The Plan cannot base decisions regarding the hiring, compensation, termination, or promotion of a claims adjudicator, medical expert, or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

D. Certain benefit determination notices and appeal notices may be required to be provided in a non-English language where a minimum number of participants are literate only in the same non-English language. Further, the notices must include additional information such as information sufficient to identify the claim involved; the denial code, its corresponding meaning, and any standard used in denying the claim; and a description of the available internal appeals and external review processes.

E. No court action may be brought by a claimant until exhausting the claim procedure provisions of the Plan. If the Plan fails to strictly adhere to the internal claim and appeal procedures prescribed by Health Care Reform, the claimant is deemed to have exhausted the internal claim and appeal procedures. As a result, the claimant may initiate an external review or file a legal proceeding.

F. A Plan must offer an external review process. If the Plan is not subject to ERISA, the Plan may be subject to the applicable state external review processes for fully insured health plans and non-ERISA self-funded health plans. If the Plan is subject to ERISA, the applicable state external review processes may also be used if the state offers access to the processes for ERISA self-funded health plans. Otherwise, the Plan will offer an external review procedure that satisfies U.S. Department of Labor regulations.

XVII. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a Participant in the Venice Christian School Health Benefit 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 Plan documents including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. 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.

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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) Benefit or exercising your rights under ERISA.

If your claim for a (pension, welfare) Benefit is denied in whole or in part you must receive a written explanation of the reason for 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 30 days, you may file suit in 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 a reason beyond the control of the administrator.

If you have a claim for Benefits that is denied or ignored, in whole or in part, you may file suit in a state or 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 the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA and the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you should contact either the nearest Area Office of the U.S. Pension and Welfare Benefits Administration, Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

XVIII. USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Plan will use Protected Health Information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

A. Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibilities for coverage and provision of plan benefits that relate to an individual whom health care is provided. These activities include but are not limited to the following:

1. Determination of eligibility;

2. Coverage and cost sharing amounts (for example, cost of a Benefit, plan maximums and Co-payments as determined for a Participant's claim;

3. Coordination of Benefits;

4. Adjudication of health benefit claims (including appeals and other payment disputes);

5. Establishing Employee contributions;

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. Billing, collection activities and related health care data processing;

8. Claims management and related health care data processing including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);

10. Medical Necessity reviews or reviews of appropriateness of care or justification of charges;

11. Utilization review, including pre-authorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name, address, date of birth, social security number, payment history, account number and name and address of the provider and/or health plan); and

13. Reimbursement to the Plan.

B. Health care operations include, but are not limited to the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and plan performance, including certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning related analysis related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. Business management and general administrative activities of the Plan, including, but not limited to:
    a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
    b. Customer service, including the provision of data analysis for Participants, Plan Sponsors or other customers.
8. Resolution of internal grievances; and
9. Due diligence in connection with the sale or transfer of assets to a potential successor or in interest, if the potential successor in interest is a covered entity under HIPAA or, following completion of the sale or transfer, will become a covered entity.

C. The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or beneficiary. With an authorization, the Plan will disclose PHI to the benefit plan of the Employer.

D. The Plan may disclose PHI to the Plan Administrator and the Plan Administrator agrees:

1. Not to use or further disclose PHI other than as permitted or required by the plan document or as required by law;
2. To ensure that any agents, including a subcontractor and the Claims Administrator, to whom the Plan Administrator provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
3. Not to use or disclose PHI for employment related actions and decisions unless authorized by the Employee;
4. Not to use or disclose PHI in connection with any other benefit or Employee benefit plan of the Plan Administrator unless authorized by the Employee;
5. To report to the Plan any PHI use or disclosure that is inconsistent with the uses and disclosures provided for of which it becomes aware;
6. To make PHI available to an individual in accordance with HIPAA's access requirements.
7. To make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. To make available the information required to provide an account of disclosures;
9. To make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Adequate separation between the Plan and the Plan Administrator must be maintained. In accordance with HIPAA, only the following Employees or classes of Employees may be given access to PHI:

1. The Benefits Manager or other authorized representative of the Plan; and/or
2. Staff designated by the Benefits Manager or other authorized representative of the Plan.

F. The persons described in this section may only have access to and use and disclose PHI for Plan administration functions that the Plan Administrator performs for the Plan.

G. If the persons described in this section do not comply with this Plan document, the Plan Administrator shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

XIX. GENERAL PROVISIONS

A. The Plan Administrator may amend the Plan at any time. No amendment shall reduce or eliminate a Participant's right to receive reimbursement in accordance with the provisions of the Plan for Qualifying HRA Expenses incurred before the date of amendment. Further, any amendment may be made retroactively to the extent permitted by the Code.

B. Although the Plan Administrator intends to continue the Plan indefinitely, the Plan Administrator reserves the right to terminate or partially terminate the Plan at any time by action of its Board of Directors. If the Plan is terminated or partially terminated for any reason, this act shall not reduce or eliminate a Participant's right to receive reimbursement in accordance with the provisions of the Plan for Qualifying HRA Expenses incurred before the date of termination.

C. The Plan Administrator shall administer the Plan in accordance with the terms of the Plan solely in the interest of the Participants and for the exclusive purpose of providing benefits to Participants and defraying the reasonable expenses of administration of the Plan. The Plan Administrator shall administer the Plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims.

The Plan Administrator shall not be liable for any act or omission relating to its duties under the Plan, unless the act or omission violates the standard of care described in this section. The Plan Administrator shall not be liable for any act or omission by another relating to the Plan.

D. All statements made by the Employer or the Employees of such Employer shall be deemed representations and not warranties, and no such statement made for the purpose of effecting Coverage shall void such Coverage or reduce Benefits unless contained in a written instrument signed by the Employer or Employee of such Employer and a copy furnished to such Employer or Employee as the case may be.

Any material misrepresentations or omissions on any written instrument to obtain insurance Coverage within three (3) years from the date Coverage continuously began shall be reason for the Plan to void any such Coverage or to deny a claim for loss.

E. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate Coverage otherwise validly in force or continue Coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future Benefits payable.

F. No representative has authority to change this Plan or waive any of its provisions. No change in this Plan shall be valid unless approved by the Plan Administrator.

G. No action at law or in equity shall be brought to recover under this Plan prior to the expiration of sixty (60) days written notice to the Plan. No such action shall be brought after the expiration of the specified statute of limitations on such action.

H. Eligible new Participants may be added to the Plan in accordance with the terms and conditions of this Plan Document and Summary Plan Description.

I. Benefit Payments are paid directly from the funds of the Employer. The Claims Administrator does not contribute funds to pay benefits, nor does the Claims Administrator have any liability to do so. Benefit payment checks issued to Participants are paid out of the Employer funds. The Claims Administrator's name may appear on the check, however, in no way should this be construed as any financial obligation on the part of the Claims Administrator.

J. Any discretionary action taken under the Plan by the Plan Administrator shall be uniform in its application to similarly situated persons and shall be based upon the objective criteria set forth in the Plan.

K. Benefits under the Plan shall be paid from the Employer's general assets. Nothing in the Plan shall be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

L. This Plan shall be construed in accordance with ERISA and the Code.

M. Notwithstanding any provision of this Plan to the contrary, the Employer and the Plan Administrator make no commitment or guaranty that any amounts paid to or for the benefit or coverage of a Participant under this Plan shall be excludable from the Participant's gross income for federal, state or local income tax purposes, or that any other particular federal, state or local tax treatment shall apply or become available to any Participant as a result of the operation of this Plan. By accepting a benefit under this Plan, a Participant agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest or penalties that may be imposed in connection with the tax.

N. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the law.