THE PAISBOA HEALTH BENEFIT PLAN
INTEGRATED HEALTH REIMBURSEMENT ARRARNGEMENT
PROGRAM PLAN DOCUMENT

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ARTICLE 1 INTRODUCTION

Section 1.01 PURPOSE OF THE PLAN

The PAISBOA Health Benefit Trust has established the PAISBOA Health Benefit Plan Integrated Health Reimbursement Arrangement ("Plan" or "HRA") effective November 1, 2023, to reimburse employees for certain eligible fertility expenses. Eligible expenses under the Plan are those expenses incurred by an Eligible Employee for medical care as defined under Code Section 213(d) for fertility benefits as further described in the Eligible Expenses Appendix to the Plan's underlying summary plan description ("SPD").

The Plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45 and an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (the "Code") and the regulations issued thereunder. The Plan is intended to be integrated with the PAISBOA Health Benefit Plan in order to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Patient Protection and Affordable Care Act, as amended ("PPACA") and the applicable regulations thereunder.

ARTICLE 2 DEFINITIONS

Account means the bookkeeping balance of an account established for each Participant as of the applicable date. The term "Account" or "Accounts" shall include account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

Active Employee means an individual who is currently an Employee of a Health Benefit Trust member school, including an Employee who is on an approved leave of absence.

Benefit Dollars means the Company's contribution, if any, to provide reimbursements for Eligible Expenses on a Participant's behalf. The Company has the sole discretion to determine the amount of such contribution (if any). Any available Benefit Dollars during the Plan Year will be communicated to Eligible Employees during the enrollment period through enrollment materials. The Benefit Dollars available under the Plan to any Eligible Employee is limited to a lifetime limit of $10,000.

Claim Administrator means the third party designated by the Plan Administrator to perform ministerial functions including verification of eligibility, enrollment management, and claim processing. The Claim Administrator for the HRA is Maven Clinic, Inc.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986, as amended.

Dependent means a dependent child, legal spouse or domestic partner of an Eligible Employee who is enrolled in the PAISBOA Health Benefit Plan.

Effective Date means November 1, 2023.

Eligible Employee means an Employee or former Employee who is enrolled in the PAISBOA Health Benefit Plan. Any Employee who is enrolled in a high deductible health plan (HDHP), as that term is defined under Internal Revenue Code

Section 223, shall not be eligible for a reimbursement under the HRA component of the Plan during any Plan Year until such Employee has satisfied the Employee's deductible under the HDHP.

Eligible Expenses means those expenses eligible for reimbursement by the Plan, as described in the SPD for this Plan.

Employee means any individual who is a common-law and active eligible employee of one of the PAISBOA Health Benefit Trust member schools. Employee status is defined in Code section 7701(a)(20). The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock or combined voting power of an S corporation. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if an Employer is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Employer in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination.

Employer means the Plan Sponsor, The PAISBOA Health Benefit Trust, and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

FMLA means the Family and Medical Leave Act of 1993 as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Participant means an Eligible Person who participates in the Plan in accordance with Article 3.

Plan means the PAISBOA Health Benefit Plan Integrated Health Reimbursement Arrangement.

Plan Administrator means the Trustees of the PAISBOA Health Benefit Trust .

Plan Sponsor means the Trustees of the PAISBOA Health Benefit Trust.

Plan Year means the 12-month period beginning November 1 and ending on October 31

ARTICLE 3 ELIGIBILITY AND BENEFITS

Section 3.01 ELIGIBLE PERSONS

Each Eligible Employee and Dependent shall be eligible for reimbursement of Eligible Expenses as described in this Plan. An Eligible Employee or Dependent will no longer be eligible to participate in this Plan on the date the Eligible Employee or Dependent ceases to satisfy the eligibility requirements set forth in this Article 3.

Participation in the Plan shall be contingent upon receipt by the Plan Administrator of such applications, consents, proofs of birth or marriage, elections, beneficiary designations, proof of reimbursable expenses, and/or other document and information as may be prescribed by the Plan Administrator, in its discretion.

Section 3.02 BENEFITS

(a) *Benefit Dollars.* A Participant's Benefit Dollars shall be determined in the sole discretion of the Company, communicated to Eligible Employees at the time of enrollment and in advance of each subsequent Plan Year thereafter. The Benefit Dollars will be reflected as an opening balance on the first day of each Plan Year in the

Participant's hypothetical Account. No earnings shall accumulate on the Benefit Dollars. The Benefit Dollars are limited to a $10,000 lifetime limit for each household (including coverage for any Dependent. Any unused balance shall carry over into the subsequent Plan Year until the $10,000 limit has been depleted. Once the limit on Benefit Dollars has been exhausted the Eligible Employee and his/her Dependents shall cease to be eligible for benefits under this Plan.

(b) *No Participant Contributions.* Participants shall not contribute to the Plan.

Section 3.03 ELIGIBLE EXPENSES

(a) *Eligible Expenses.* A Participant may be reimbursed from the Plan for the Eligible Expenses specified in the SPD for the Plan, provided that such expenses are not covered, paid, or reimbursed from any other source.

(b) *Ineligible Expenses.* Expenses incurred by individuals who are not enrolled in the PAISBOA Health Benefit Plan, or who are not covered by this Plan when the expense is incurred, are not eligible for reimbursement under the Plan. Furthermore, any expense incurred by a Participant prior to the Participant satisfying the deductible under the HDHP shall not be eligible for reimbursement under the Plan.

(c) Covered Expense. Reimbursement shall be provided to any individual only for Eligible Expenses incurred while that individual is a Participant or a COBRA Participant (with respect to the HRA only. The Adoption & Surrogacy reimbursement portion of the Plan is not subject to COBRA). Eligible Expenses may be reimbursed from a Participant's Account only to the extent that the Participant incurring the expense after the Effective Date and the Eligible Expense is not reimbursed for the expense (nor is the expense reimbursable) through any other group health plan, individual health policy or any other insurance policy. If only a portion of an Eligible Expense has been reimbursed elsewhere, the Plan may reimburse the remaining portion of such expense if it otherwise meets the requirements of the Plan.

Section 3.04 REIMBURSEMENT

(a) *Period for Submitting Claims.* A Participant may submit a request for reimbursement under the Plan during the Period of Coverage and no later than 90 days from the service date, which is the date specified in the SPD for the Plan. The claim for reimbursement must be made via the Maven Wallet. This manner is acceptable to the Plan Administrator and must include such proof of claim that substantiates the Eligible Expense as the Plan Administrator deems satisfactory.

(b) *Payment of Claims.* At all times during the Plan Year, a Participant or COBRA Participant shall be entitled to benefits under this Plan in an amount that does not exceed the balance of his Account for payment of Eligible Expenses. Each payment hereunder shall be a charge to such Account available to pay Eligible Expenses under the Plan. All amounts in the Account are available to the Participant for the Eligible Expenses of the Participant. Notwithstanding any other provision of the Plan to the contrary, once a Qualifying Event (as defined under COBRA) occurs, payments to a Participant or COBRA Participant under the Plan shall be charges to amounts available to pay Eligible Expenses under the Plan for the current and any subsequent Plan Year with respect to any COBRA Participant whose right to continue to participate in the Plan derives from a relationship to the Participant. To the extent that a Participant has a balance in his Account at the end of a Plan Year, a portion of the balance may roll over to subsequent Plan Year(s). The amount eligible to roll over shall be determined in the sole discretion of the Plan Administrator. Notwithstanding anything to the contrary, the Participant's reimbursements under the Plan will be limited to the balance of the Participant's Account.

(c) *Documentation Requirement*. Prior to making any payment of benefits under the Plan, the Claims Administrator will require the Participant to provide such evidence of Eligible Expenses as is sufficient to enable the Claims Administrator to determine that the expense qualifies as an Eligible Expense for reimbursement and to make an accurate determination of the amount of benefit to be paid. Such evidence shall consist of information from an

independent third-party that describes the service or product, the date of the sale or service, and the amount. Self-substantiation of the expense by the Participant is not sufficient. Acceptable forms of substantiation also include an explanation of benefits from an insurance company or third-party administrator.

(d) *Coordination of Benefits; Coordination with Health Flexible Spending Accounts.* Benefits under this Plan are solely intended to reimburse Eligible Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Eligible Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's Eligible Expenses are covered by both this Plan and by a Health Flexible Spending Account, then this Plan shall not be available for reimbursement of such Eligible Expenses until after amounts available for reimbursement under the Health Flexible Spending Account have been exhausted.

Section 3.05 TERMINATION OF COVERAGE

Participation by a Participant in the Plan shall cease upon the date the individual fails to qualify as a Participant and, in such case, expenses incurred after the date the individual fails to qualify as a Participant are not eligible for reimbursement under the Plan and any unused balance shall be forfeited.

ARTICLE 4 NONDISCRIMINATION

Section 4.01 NONDISCRIMINATION REQUIREMENTS

The Plan may not discriminate in favor of highly compensated individuals as defined in Code section 105(h)(5) as to benefits provided or eligibility to participate.

Section 4.02 ADJUSTMENTS

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Section 4.02 shall be carried out in a uniform and non-discriminatory manner.

ARTICLE 5 PLAN ADMINISTRATION

Section 5.01 PLAN ADMINISTRATOR

(a) *Powers of the Plan Administrator.* The Plan Administrator shall have the discretionary power and authority to:

(1) Interpret the Plan, make factual determinations and decide all matters arising under the Plan;

(2) Prescribe rules for the operation of the Plan;

(3) Determine eligibility and enroll employees in the Plan;

(4) Comply with the requirements of reporting and disclosure under ERISA and any other applicable law and to prepare and distribute other communications to employees as part of the plan operations;

(5) Prescribe forms to facilitate the operation of the Plan;

(6) Construe and interpret the terms of the Plan including the power to remedy possible ambiguities, inconsistencies or omissions;

(7) Determine the amount of benefits and eligibility for benefits;

(8) Implement computer and telecommunications systems to assist administration of the Plan and maintain records of the Plan;

(9) Litigate, settle claims, and respond to and comply with court proceedings and orders on the Plan's behalf;

(10) Prepare, approve and execute other supporting documents which are necessary or appropriate for the operation of the Plan and on the Plan's behalf, including, without limitation, plan descriptions, insurance contracts, and contracts with service-providers.

(11) Research, hire and fire, negotiate terms with, manage the relationship with, and authorize payments to insurance companies, recordkeepers, administrators, claims processors, legal, accounting, actuarial, computer services and consulting firms and other vendors, which are necessary or appropriate for the operation of the Plan.

(b) *Allocation or Delegation of Duties and Responsibilities.* The Plan Administrator may:

(1) Interpret the Plan and decide all matters arising under the Plan;

(2) Prescribe rules for the operation of the Plan;

(3) Determine eligibility and enroll employees in the Plan;

(4) Comply with the requirements of reporting and disclosure under ERISA and any other applicable law and to prepare and distribute other communications to employees as part of the plan operations;

(5) Prescribe forms to facilitate the operation of the Plan;

(6) Construe and interpret the terms of the Plan including the power to remedy possible ambiguities, inconsistencies or omissions;

(7) Determine the amount of benefits and eligibility for benefits;

(8) Implement computer and telecommunications systems to assist administration of the Plan and maintain records of the Plan;

(9) Litigate, settle claims, and respond to and comply with court proceedings and orders on the Plan's behalf;

(10) Prepare, approve and execute other supporting documents which are necessary or appropriate for the operation of the Plan and on the Plan's behalf, including, without limitation, plan descriptions, insurance contracts, and contracts with service-providers.

(11) Research, hire and fire, negotiate terms with, manage the relationship with, and authorize payments to insurance companies, recordkeepers, administrators, claims processors, legal, accounting, actuarial, computer services and consulting firms and other vendors, which are necessary or appropriate for the operation of the Plan.

(c) *Allocation of Duties and Responsibilities.* The Plan Administrator may:

(1) Employ agents to carry out nonfiduciary responsibilities.

(2) Delegate fiduciary responsibilities (other than trustee responsibilities as defined in Section 405(c)(3) of ERISA) among their members under the rules of the next Section.

(3) Consult with counsel, who may be counsel for the Plan Sponsor.

(4) Allocate fiduciary responsibilities (other than trustee responsibilities as defined in Section 405(c)(3) of ERISA) among their members under the rules of the next Section.

(5) Designate one or more individuals to have responsibility for designing and implementing administrative procedures for the Plan.

(d) *Compensation.* The Plan Administrator shall serve without compensation for its services.

(e) *Expenses.* All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Plan Sponsor.

Section 5.02 INDEMNIFICATION

The Company and the Employers agree to and shall indemnify and hold harmless each Indemnified Person (as defined in this Section) from and against any and all claims, losses, damages, causes of action, suits, and liability of every kind, including all expenses of litigation, court costs and reasonable attorney's fees, incurred in connection with the Plan" "Indemnified Person" shall mean each member of the Benefits Group and each employee, officer or director of the Company or of an Employer acting as a fiduciary of the Plan. Such indemnity shall apply regardless of whether the claims, losses, damages, causes of action, suits, or liability arise in whole or in part from the negligence or other fault on the part of the Indemnified Person, except to the extent there has been a final adjudication that the claim or liability results from the gross negligence or willful misconduct of the Indemnified Person.

Section 5.03 Section 5.03 MISSING PERSON

Unless otherwise determined, if any amount becomes payable under the Plan to a Participant or any of his Dependents and the same shall not have been claimed, or if any check issued under the Plan remains uncashed, and reasonable care shall have been exercised by the Plan Administrator in attempting to make such payments, the amount shall be forfeited within such period as is necessary to prevent escheat under any applicable law and shall cease to be a liability of the Plan. Notwithstanding the foregoing, in the event a Participant or his Dependent is later found, the Plan Administrator shall repay any amount forfeited, without earnings to the applicable Participant or Dependent.

Section 5.04 Section 5.04 PARTICIPANT RESPONSIBILITIES

Each Participant shall be responsible for providing the Plan Administrator and the Company with the Participant's, covered spouse's, dependent's and beneficiary's current address. Any notices required or permitted to be given under this Section shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Company shall have any obligation or duty to locate a Participant, covered spouse, dependent or beneficiary. In the event that a Participant, covered spouse, dependent or beneficiary becomes entitled to a payment under the Plan and such payment is delayed or cannot be made because of one of the following reasons, then the amount of such payment, if and when made, shall be that determined under the provisions of the Plan without consideration of any interest which may have accrued. The provision applies if:

(a) the *current* address on file in Company records is incorrect;

(b) the *Participant*, covered spouse, dependent or beneficiary fails to respond to the notice sent to the current address according to Company record;

(c) there are conflicting claims to such payments;

(d) any other event occurs and is determined to result in the application of this provision in the sole discretion of the Plan Administrator

(e) providing social security numbers as required under applicable law.

ARTICLE 6 AMENDMENT AND TERMINATION

Section 6.01 AMENDMENT

The Plan Sponsor or any delegate thereof, may amend any part or all of the Plan, at any time and for any reason within its sole discretion. No amendment shall operate to reduce the amount of any benefit payment or claim submitted for reimbursement prior to the effective date of such amendment.

Section 6.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will continue indefinitely; however, the Plan Sponsor reserves the right to terminate the Plan or any part thereof at any time and for any reason within its sole discretion. No termination shall operate to reduce the amount of any benefit payment otherwise payable under the Plan for claims incurred and submitted for reimbursement prior to the effective date of such termination.

(b) A participating Employer's participation in this Plan shall terminate upon written notice to the Plan Sponsor of its intent to terminate participation in the Plan.

Section 6.03 PARTICIPATING EMPLOYERS

By virtue of its participation in the Plan, a participating Employer accepts, and agrees to be bound by, the terms and conditions of the Plan. The participating Employer consents to the Plan Sponsor's sole authority (without further signature or other action by the participating Employer) to amend or to terminate the Plan, to terminate the participating Employer's participation in the Plan, and to take all other actions within the authority of the Plan Sponsor.

ARTICLE 7 CLAIMS PROCEDURES

Section 7.01 CLAIMS

Plan claims shall be administered in accordance with 29 CFR 2560.503-1. In order to receive a reimbursement under the Plan, the Participant (or his beneficiary, in the event of the Participant's death) shall file a claim in writing and set forth the facts the Participant bringing the claim (the "Claimant") believes entitles him or her to reimbursement under the Plan. Claims must be submitted to the Claim Administrator. The amount that may be submitted as a claim shall not be less than the minimum reimbursement amount established by the Plan Administrator, unless such claim represents the final claim for a Plan Year. The form must require the Participant to certify that the expenses have not been reimbursed elsewhere and that the employee will not seek reimbursement from any other plan covering health benefits. The claim(s) must be filed by the end of the last day of the third month following the end of the Plan Year. Upon the approval of a claim by the Claims Administrator, the Participant shall be entitled to reimbursement on no less than a monthly basis, but in no event shall the total dollar amount of approved claims exceed the amount in the Account.

(a) *Timing of Notice of Denied Claim.* The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claim Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required

information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(b) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Claim Administrator shall provide the Claimant with a notice identifying (A) information about the claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available, (B) any denial code (and its corresponding meaning) that was used in denying the claim, (C) the reason or reasons for such denial, (D) reference to the pertinent Plan provisions on which the denial is based, (E) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (F) an explanation of the steps that the Claimant must take if he wishes to appeal the denial and the time limits applicable to such steps, including a statement that the Claimant may bring a civil action under section 502(a) of ERISA following an adverse benefits determination on review, and (G)(1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(c) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, they shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Claim Administrator's notice that the claim has been wholly or partially denied. The Claimant shall lose the right to appeal if the appeal is not timely made. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. An appeal must be in writing, must be provided to the Plan Administrator, and must include the following information:

(1) Claimant’s name and address;

(2) The fact that Claimant is disputing a denial of a claim or the Claim Administrator’s act or omission

(3) The date of the notice that the Claim Administrator informed the Claimant of the denied claim; and

(4) The reason(s), in clear and concise terms, for disputing the denial of the claim or the Claim Administrator’s act or omission.

An appeal should also include any relevant documentation not already provided to the Claim Administrator.

If the Claim Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that Claimant has provided to it, Claimant will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Claim Administrator’s notice of final internal adverse benefit determination. Similarly, if the Plan Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to Claimant and Claimant will be given a reasonable opportunity to respond to that new rationale before the due date for the Claim Administrator's notice of final internal adverse benefit determination.

Claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. Any time before the appeal deadline, Claimant may submit copies of all relevant documents, records, written comments,

testimony, and other information to the Claim Administrator. The Plan is required to provide Claimant with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing an appeal, the Claim Administrator shall take into account all relevant documents and other information that the Claimant provides with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination. The Claim Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Administrator may deem relevant. In considering the appeal, the Claim Administrator shall:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is not the individual who made the adverse benefit determination that is the subject of the appeal, the subordinate of such individual, or an individual whose terms and conditions of employment are affected by the results of his decision;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Claim Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made. If an appeal is timely made, the Claimant has the right to an internal appeal and, if applicable, an external review to an independent review organization.

The Claimant will not be allowed to take legal action against the Plan, the Claim Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless he exhausts his internal appeal rights. But the Claimant is not required to pursue external review in order to preserve his right to file a lawsuit.

(b) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) information about the claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available, (B) the reason or reasons for such denial, (C) reference to the pertinent Plan provisions on which the denial is based, (D) any denial code (and its corresponding meaning) that was used in denying the claim, (E) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, (F) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the review determination, either the rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the Claimant free of charge upon request, and (G) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures.

(c) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Before a suit can be filed in federal court, claims must exhaust internal procedures and remedies. This exhaustion requirement applies to all types of claims

under the Plan, including: (i) recovery of benefits under the Plan, (ii) enforcement of a Participant's rights under the terms of the Plan, and (iii) clarification as to a Participant's rights to future benefits under the terms of the Plan. A claim or action (i) to recover benefits allegedly due under the Plan or by reason of any law, (ii) to enforce rights under the Plan, (iii) to clarify rights to future benefits under the Plan, or (iv) that relates to the Plan and seeks a remedy, ruling or judgment of any kind against the Plan or a Plan fiduciary or party in interest (collectively, a "Judicial Claim"), may not be commenced in any court or forum until after the claimant has exhausted the Plan's claims and appeals procedures (an "Administrative Claim"). A claimant must raise every argument and/or produce all evidence the claimant believes supports the claim or action in the Administrative Claim and shall be deemed to have waived any argument and/or the right to produce any evidence not submitted to the Claim Administrator or its delegate as part of the Administrative Claim. Any Judicial Claim must be commenced in the appropriate court or forum no later than 24 months from the earliest of (A) the date the first benefits were paid or allegedly due; (B) the date the Claim Administrator or its delegate first denied the claimant's request; or (C) the first date the claimant knew or should have known the principal facts on which such claim or action is based; provided, however, that, if the claimant commences an Administrative Claim before the expiration of such 24 month period, the period for commencing a Judicial Claim shall expire on the later of the end of the 24 month period and the date that is three months after final denial of the claimant's Administrative Claim, such that the claimant has exhausted the Plan's claims and appeals procedures. Any claim or action that is commenced, filed or raised, whether a Judicial Claim or an Administrative Claim, after expiration of such 24-month period (or, if applicable, expiration of the three-month period following exhaustion of the Plan's claims and appeals procedures) shall be time-barred. Filing or commencing a Judicial Claim before the claimant exhausts the Administrative Claim requirements shall not toll the 24-month limitations period (or, if applicable, the three-month limitations period).

Section 7.02 REFUNDS/INDEMNIFICATION

If the Plan Administrator determines that any individual has directly or indirectly received excess payments/reimbursements, the Plan Administrator shall notify the individual and the individual shall repay such excess amount as soon as possible, but in no event later than 30 days after the date of notification. An individual shall indemnify and reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the individual fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (a) to the extent permitted by applicable law, offset the individual salary or wages, and/or (b) offset other benefits payable hereunder.

ARTICLE 8 MISCELLANEOUS

Section 8.01 NONALIENATION OF BENEFITS

No Participant shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments that he or she may expect to receive, contingently or otherwise, under the Plan.

Section 8.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and the Participant, or as a right of any individual to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its employees, with or without cause.

Section 8.03 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount *contributed* by the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made solely out of the general assets of the Employer.

(b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan, and no person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have *rights* to, or interest in, any benefit or account other than as expressly authorized in the Plan.

(d) Benefits under the Plan shall be funded solely by assets of the Employer. Contributions to the Plan by Employees, directly or *indirectly*, are prohibited.

(e) This Plan is paid for solely by *the* Employer and is not provided pursuant to any salary- reduction election or otherwise under a Code section 125 cafeteria plan. Neither the Employee nor any other person has the right, currently or for any future year, to receive any benefit other than the reimbursement of substantiated eligible medical care expenses incurred by the Employee and the Employee's spouse and dependents.

Section 8.04 NO CASH OUT

The Plan shall not make payment to any individuals of unused benefits.

Section 8.05 DEATH

If a Participant dies, the Participant's beneficiaries may submit claims for Eligible Expenses for the portion of the Period of Coverage preceding the date of the Participant's death, subject to the terms of the Plan. A Participant may designate a specific beneficiary provided that such beneficiary is the Participant's spouse or one or more of the Participant's dependents. Any such beneficiary designation shall be in a form prescribed by the Plan Administrator and will be effective only when filed as directed by the Plan Administrator during the Participant's lifetime, and shall be subject to and conditioned upon any and all provisions of federal law regarding the choice of beneficiary. Each properly filed beneficiary designation will cancel all previously filed beneficiary designations. If no beneficiary is specified (or if the beneficiary designation is invalid for any reason), the Plan Administrator may pay any amount due hereunder to the Participant's spouse or, if there is no spouse, to the Participant's dependents in equal shares or, if there are no spouse or dependents, to the estate of the Participant. Such payment shall fully discharge the Plan Administrator and the Employer from further liability on account thereof.

Section 8.06 LAWS APPLICABLE TO GROUP HEALTH PLANS

Benefits under the Plan shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws, and all regulations thereunder, to the extent required by such laws and regulations and only to the extent such benefit or benefit component of the Plan is subject to those provisions. If the Plan is subject to COBRA (Code section 4980B and other applicable state law), a Participant shall be entitled to continuation coverage as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes. In the event of any conflict between any part, clause, or provision of the Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of the Plan shall be deemed superseded to the extent of the conflict.

Section 8.07 NO GUARANTEE OF TAX CONSEQUENCES

The Plan Administrator and the Employer do not make any guarantee that the amounts paid to the Participant hereunder will be excludable from the Participant's gross income for federal, state, or local tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes.

Section 8.08 PLAN PROVISIONS CONTROL

In the event that the terms of any summary or description of the Plan conflict or are inconsistent in any way with the terms of the Plan, the provisions of the Plan shall control.

Section 8.09 GOVERNING LAW

The Plan shall be construed, administered, and enforced according to the laws of the Commonwealth of Pennsylvania, to the extent not superseded by the Code, ERISA, or any other federal law.

Section 8.10 HEADINGS

The headings of the various Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

Section 8.11 SEVERABILITY

If any part of the Plan is subsequently invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

ARTICLE 9 HIPAA PRIVACY AND SECURITY COMPLIANCE

The Plan shall comply with the standards for privacy of protected health information as set forth in the privacy rule, the security standards for the protection of electronic protected health information as set forth in the security rule, and the notification requirements for breaches of unsecured protected health information under the breach notification rule. References to "Plan" for purposes of this Article 9 shall be limited to group health plan benefits only.

Section 9.01 DEFINITIONS

For purposes of this Article 9, the following terms have the following meanings:

(a) Business Associate means any outside vendor who performs a function or activity on behalf of the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) Group Health Benefits means benefits offered under the Plan that constitute a group health plan as defined in section 2791(a)(2) of the Public Health Service Act.

(c) Individual means the Participant enrolled in any of the Group Health Benefits under the Plan or a Participant's covered dependent.

(d) Notice of Privacy Practices means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) Plan Administration Functions means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) Protected Health Information or PHI means information about an individual, including genetic information (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan;

(2) relates to the past, present or future physical or mental health or condition of the individual, the provision of health care to the individual, or the past, present or future payment for the provision of health care to the individual; and

(3) identifies the individual or with respect to which there is a reasonable basis to believe the information may be used to identify the individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) Summary Health Information means information summarizing the claims history, claims expenses, or types of claims experienced by an individual, and from which the following information has been removed:

(1) names;

(2) any geographic information which is more specific than a five-digit zip code;

(3) all elements of dates relating to a covered individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered individual if the individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) facial photographs or biometric identifiers (e.g., finger prints); and

(6) any other unique identifying number, characteristic, or code.

Section 9.02 HIPAA PRIVACY COMPLIANCE

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

(i) To provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;

(ii) for auditing claims payments made by the Plan;

(iii) to request proposals for services to be provided to or on behalf of the Plan; and

(iv) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.

(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

(3) The Plan may disclose to the Plan Sponsor information regarding whether an individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.

(3) The Plan Sponsor will not use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

(5) The Plan Sponsor will make a covered individual's PHI available to the covered individual in accordance with the Privacy Rule.

(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor who are identified in the Plan's HIPAA Policies and Procedures may be given access to PHI received from the Plan or Business Associate servicing the Plan.

(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining health insurance coverage or premium bids for health plans.

(2) The Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

Section 9.03 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

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

(d) Report to the Plan any security incident of which it becomes aware.