City of Springfield

PLAN DOCUMENT
Health Reimbursement Arrangement

Effective: 1/1/2022

With Third Party Administrative Services Provided By:

IRC Section 105 requires that your Plan Document be kept on file.
This document explains in detail the operation and rules that govern your Plan.

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ARTICLE I - Purpose of Plan and Legal Status

City of Springfield (the "Employer") hereby adopts this Health Reimbursement Arrangement (the "Plan"), effective as of the date specified in Section III of the Summary Plan Description, either as an initial establishment or as the restatement of a previously implemented plan. Capitalized terms used in this document, and not otherwise defined, shall have the meanings set forth in Article II.

1.01 Purpose This Plan is specifically intended to qualify as an Employer-provided reimbursement plan under Code Sections 105 and 106 and regulations issued thereunder, and as a Health Reimbursement Arrangement ("HRA") as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b).

This Plan is intended to permit an eligible Employee to obtain reimbursement of expenses on a nontaxable basis from the account.

1.02 Limitations on Provisions The provisions of the Plan and any benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other Employee benefit plan maintained by the Employer shall be paid solely in accordance with the terms and provisions of such benefit plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

1.03 Source of Funds Benefits under the Plan shall be paid for solely by contributions of the Employer and not by any Employee through salary reduction contributions or otherwise.

1.04 Tax Compliance The Plan is intended to result in favorable tax treatment to Participants, Beneficiaries or the Employer, as the case may be. The Plan is therefore intended to comply with any requirements of the Code and regulations thereunder which impose conditions to such favorable tax treatment.

To the extent the Plan is required to satisfy a standard or other prerequisite to favorable tax treatment, the Plan is intended to facilitate and ensure compliance therewith. Notwithstanding any other terms of the Plan, the Plan is hereby intended to be legally enforceable, and shall be maintained for the exclusive benefit of Participants.

The Plan will be operated in accordance with the nondiscrimination requirements of Section 105(h) of the Code and any regulations thereunder. The Employer reserves the right to take whatever steps are necessary to maintain this Plan as nondiscriminatory, including the right to adjust the amount of nontaxable benefits available to Employees. Any such reduction of nontaxable benefits will be accomplished by reducing proportionately the nontaxable benefits available to Highly Compensated Individuals, as defined in Section 105(h) of the Code.

This Plan is not part of any cafeteria plan under Code Section 125.

ARTICLE II - Definitions

2.01 "**Account**" means the Health Reimbursement Arrangement ("HRA") account.

2.02 "**Active Participant**" mean a Participant who continues to be an eligible Employee and is or remains eligible to receive additional credits to the Participant's HRA.

2.03 "**Beneficiary**" means a person who is eligible to receive benefits under the Plan by reason of another individual's active or former service with the Employer.

2.04 "**Benefits**" means the reimbursement benefits for healthcare expenses described under Article 5.01.

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

2.06 "**Code**" means the Internal Revenue Code of 1986, as amended.

2.07 "**Compensation**" means all the earned income, salary, wages and other earnings except bonuses and overtime paid by the Employer to an Employee during a plan year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 132(f)(4), 401(k), 403(b), 408(k) or 457(b) of the Code.

2.08 "**Covered Person**" means a Participant and the Participant's Spouse and/or Dependents to the extent provided in the Summary Plan Description.

2.09 "**Credit Amount**" means the amount determined in Section III of the Summary Plan Description to be credited to a Participant's HRA on a Credit Date.

2.10 "**Dependent**" means (a) any individual who is a Participant's child as defined by Code §152(f)(1) and who has not attained age 27, and (b) any tax dependent of a Participant as defined in Code §105(b) provided, however, that any child to whom Code §152(e) (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) applies is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

2.11 "**Effective Date**" of this Plan is the date specified in Section III of the Summary Plan Description.

2.12 "**Electronic Payment Card**" means a debit card, stored value card, or credit card that allows a Participant to access funds in an account pay the service provider at the point-of-sale (i.e., the time a service or item is provided).

2.13 "**Electronic Protected Health Information**" has the meaning described in 45 C.F.R. Section 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted,

Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

2.14 "**Eligible Employee**" means an Employee who satisfies all conditions of eligibility elected in Section III of the Summary Plan Description. An eligible Employee remains an eligible Employee only so long as the individual continues to satisfy all such conditions of eligibility.

2.15 "**Healthcare Expenses**" has the meaning defined in Article 5.05.

2.16 "**Eligibility Period**" means the time period that a Participant can incur eligible expenses for reimbursement.

2.17 "**Employee**" means a person who is currently or hereafter employed by the Employer and any Affiliate Employers that have adopted the Plan.

2.18 "**Employment Commencement Date**" means the first regularly-scheduled working day on which the Employee first performs an hour of service fo**r** the Employer for Compensation.

2.19 "**Entry Date**" means the date(s) designated in Section III of the Summary Plan Description on which eligible Employees can commence participation.

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

2.21 "**FMLA**" means the Family and Medical Leave Act of 1993, as amended.

2.22 "**Fund**" means the account or fund, if any, established by the Employer to receive and hold contributions made pursuant to Article 4.02.

2.23 "**GINA**" means the Genetic Information Nondiscrimination Act of 2008.

2.24 "**Group Sponsored Insurance Plan**" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies, dental care, vision care, etc. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

2.25 "**Health FSA**" means a "Health Flexible Spending Account" as defined under Code Section 106 and applicable treasury regulations, which is offered as part of a cafeteria plan sponsored by the Employer.

2.26 "**High Deductible Health Coverage (HDHC)**" means a general term for coverage under a health plan with a higher than normal deductible.

2.27 "**Highly Compensated Individual**" means an individual defined under Code Section 105(h), as amended, as a "Highly Compensated Individual" or "Highly Compensated Employee."

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

2.29 "**HITECH**" means the Health Information Technology for Economic and Clinical Health Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009.

2.30 "**HRA**" means a Health Reimbursement Arrangement as defined in IRS Notice 2002-45.

2.31 "**Inactive Participant**" means a Participant, who is no longer an eligible Employee for any reason and is not eligible to receive additional credits to the Participant's account, but still has a balance remaining in such account and continues to participate by being able to submit claims for reimbursement as provided in Article III.

2.32 "**Key Employee**" means any Employee who is a Key Employee as defined in Section 416(i) (1) of the Code.

2.33 "**MHPA**" means the Federal Mental Health Parity Act.

2.34 "**MHPAEA**" means the Federal Mental Health Parity Addiction Equity Act.

2.35 "**Michelle's Law**" means the Federal law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

2.36 "**NMHPA**" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

2.37 "**Participant**" means any Employee who is eligible to participate, has entered the Plan and begun participating as provided in Article III, and has not for any reason become ineligible to participate further in the Plan. A Participant may be either an active Participant or an inactive Participant. Former Employees are also considered "Employees" of the Employer strictly for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the plan year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

2.38 "**Period of Coverage**" means the plan year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the plan year following the date on which participation commences, as described in Article 3.02; and (b) for Employees who terminate participation, it shall mean the portion of the plan year prior to the date on which participation terminates, as described in Article III.

2.39 "**Plan**" means this HRA Plan, together with any and all amendments and supplements required by the Code.

2.40 "**Plan Administrator**" means City of Springfield. The contact person is the Human Resources Manager for City of Springfield, who has the full authority to act on behalf of the Administrator, except with respect to appeals, for which the Committee or other designated person(s) have the authority to act on behalf of the Administrator, as described in Article 6.01.

2.41 "**Plan Year**" means the period specified in Section III of the Summary Plan Description.

2.42 "**PPACA**" means the Patient Protection and Affordable Care Act.

2.43 "**Privacy Official**" has the meaning described in 45 CFR § 164.530(a).

2.44 "**Protected Health Information**" (PHI) shall have the meaning described in 45 C.F.R. Section 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

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

2.46 "**Related Employer**" means any Employer affiliated with Employer that, under Code Section 414(b), (c), (m) or (o), is treated as a single Employer with Employer for purposes of Code Section 105.

2.47 "**Required Health Insurance Plan**" means a Health Insurance Plan designated in Section III of the Summary Plan Description in which the Employer requires an individual to be enrolled in order for the individual to be a Participant in this Plan.

2.48 "**Run-Out Period**" means a period after the close of a plan year or other period during which Participants may request reimbursement for expenses incurred during the period of coverage.

2.49 "**Spouse**" means an individual of same-sex or opposite sex who is legally married to a Participant as determined under applicable federal and/or state law (and who is treated as a spouse under the Code).

2.50 "**Third Party Administrator**" means PacificSource Administrators, Inc. ("PSA").

2.51 "**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

2.52 "**WHCRA**" means the Federal Women's Health and Cancer Rights Act.

ARTICLE III - Eligibility and Participation

3.01 General Once an Employee has met the Plan's eligibility requirements, the Employee may commence participation in the Plan as of the Entry date specified by the Employer and no Enrollment Form is required.

3.02 Participation Employees who are regularly scheduled to work at or above the level specified in Section III of the Summary Plan Description shall be eligible to participate in the Plan as of the Effective Date. To the extent in Section III of the Summary Plan Description excludes one or more category of Employees, those identified shall not be eligible to participate in the Plan.

A Participant shall cease to be an active Participant in the Plan as of the earliest of:

- The date the Participant ceases to satisfy the eligibility requirements as specified in Section III of the Summary Plan Description (provided that active participation may continue beyond such date if COBRA coverage is available, elected and the COBRA premiums are timely paid); or
- The date on which the Plan is terminated.

A Participant shall cease to be an inactive Participant in the Plan as of the earliest date the Participant has no right to any benefit under the Plan.

3.03 Special Eligibility and Participation Rules

(a) Eligible Employees Who Terminate Employment Prior to Participation If an eligible Employee terminates employment prior to the Employee's Entry Date (and thus does not become a Participant), and thereafter is rehired, the Employee shall be treated as a new Employee for purposes of satisfying all conditions of eligibility, unless stated otherwise in Section III of the Summary Plan Description.

(b) Eligible Employees Who Lose Eligibility Prior to Participation for Reasons Other Than Termination of Employment If an eligible Employee loses eligibility for reasons other than termination of employment prior to the Employee's Entry Date (and thus does not become a Participant), and thereafter satisfies all conditions of eligibility, the eligible Employee shall become a Participant on the later of the original Entry Date or the date the Employee again satisfies all such conditions of eligibility, unless stated otherwise in Section III of the Summary Plan Description.

(c) **Current Participants Who Lose Eligibility** If a Participant loses eligibility but does not terminate employment the individual shall regain eligibility on the date the individual meets eligibility requirements, unless stated otherwise in Section III of the Summary Plan Description.

3.04 Participation Following Termination of Employment or Loss of Eligibility If a Participant terminates his or her employment, or ceases to be an eligible Employee, for any reason, including, but not limited to, disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of termination of employment and is otherwise eligible to participate in the Plan, then the Employee may immediately rejoin the Plan and be reinstated with the same account balance that such individual had before termination unless stated otherwise in Section III of the Summary Plan Description.

If an Employee (whether or not a Participant) terminates employment and is rehired greater than 30 days after termination for any other reason, including, but not limited to, a reduction in hours, and then becomes an eligible Employee again, the Employee will be treated as a new hire and must re-satisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan as described in Article 3.01 before becoming eligible to participate in the Plan unless otherwise specified in Section III of the Summary Plan Description.

3.05 FMLA and USERRA Leaves of Absence Notwithstanding any provision to the contrary in this Plan, if Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, or similar applicable State medical or military leave laws, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active eligible Employee.

3.06 Non-FMLA and Non-USERRA Leaves of Absence If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, or similar applicable State medical or military leave laws, the Participant will be treated as having terminated participation, as described above under Article 3.04.

ARTICLE IV - Benefits and Method of Funding

4.01 Establishment of Account When an eligible Employee becomes a Participant, the Employer will establish and maintain an account for each Participant to receive Benefits in the form of reimbursements for eligible expenses, as described in Section III of the Summary Plan Description. The Employer will not be required to create a separate fund or otherwise segregate for this purpose. The account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

The Plan is fully funded by the Employer. Under no circumstances may a Participant individually contribute to his or her HRA. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for healthcare expenses.

Except for administrative expenses charged to an account, distributions from a HRA may only occur in connection with a reimbursement for eligible expenses, as described more specifically in Article 5.05. Under no other circumstances may a Participant (or his or her Spouse or Dependents) receive payment from this Plan, except for the reimbursement of eligible expenses that have not been paid or reimbursed by a health insurance plan or any other plan, program or source that pays or reimburses eligible expenses. Reimbursement amounts may be paid directly to the healthcare provider in lieu of reimbursing the Participant directly.

4.02 Change in Status A qualified change in status may allow your Employer to make a mid-plan year change or revocation to your annual credit maximum amount. The Employer, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a change in status. In this regard, a change in status is any of the following:

- An event that changes the Participant's legal marital status, including marriage, death of a spouse, legal separation, divorce, or annulment;
- An event that changes the number of the Participant's dependents, including by reason of birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events that change the employment status of the Participant or the Participant's spouse or dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in work site; and any change in employment status that causes the Participant, Participant's spouse or Participant's dependent to become (or cease to be) eligible under this Plan, any Employee benefit plan underlying this Plan, or any plan or Employee benefit plan of the Employer of the Participant's spouse or Participant's dependent (e.g., a change from hourly to salaried status where such change affects eligibility);
- An event which causes a dependent to satisfy or cease to satisfy the eligibility requirements for coverage due to attainment of age, student status or any similar circumstance as provided in the applicable plan;
- A change in the place of residence of the Participant or the Participant's spouse or dependent.

Employees that experience a qualified change in status should contact their Employer within 30 days of that event or as soon as possible after the event occurs.

ARTICLE V - Health Reimbursement Arrangement

5.01 Benefits The Plan will reimburse Participants for healthcare expenses up to the unused amount in the Participant's account, as set forth and adjusted under Article 5.02. A Participant's account will be debited during each period of coverage for any reimbursement of expenses incurred during the period of coverage. The amount available for reimbursement of expenses is the amount credited to the Participant's account reduced by prior reimbursements.

(a) Medical Care Expenses - General: "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code §213 (including, for example, amounts for certain hospital, doctor, and dental bills), but shall not include expenses that are described in subsection B. Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents shall be charged against the Participant's HRA Account.

(b) Medical Care Expenses - Exclusions: "Medical Care Expenses" shall not include (1) any other group health plan; (2) unprescribed medicines or drugs (other than insulin), without regard to whether such medicine or drug could be obtained without a prescription; (3) any expense that the Plan will not cover; and (4) any other expenses listed specifically as an exclusion in Section 5.06.

5.02 Maximum Benefits Section III of the Summary Plan Description shall prescribe the maximum dollar amounts, if any, that may be credited to the accounts of Employees who are active Participants for a full plan year (the "Annual Credit Amount"). The annual credit amount need not be the same for every Participant, and may vary among different classes of active Participants, including for example, based on the type of coverage the Participant has elected under a Group Sponsored Insurance Plan (e.g., Employee-only or family coverage); provided, however, that the Plan shall not violate applicable nondiscrimination provisions; and provided further that if no such criteria are designated, the annual credit amount shall be the same for all who are active Participants for the full plan year.

On each credit date in the coverage period, the Employer will credit each active Participant's account with the applicable credit amount as specified in Section III of the Summary Plan Description. Amounts credited on a Credit Date may be temporarily credited on such date, with consequences as provided in Section III of the Summary Plan Description and Article 4.7.

For each coverage period, the maximum dollar amount available for reimbursement under the account of an Employee who is an active Participant for a full plan year will be the amount credited for the coverage period plus the amount (if any) carried over from prior coverage periods subject to any limitations on the amount carried over as provided in Section III of the Summary Plan Description.

5.03 Carryover of Accounts If any balance remains in the Participant's account for a coverage period after all reimbursements have been made for the coverage period, then to the extent provided in Section III of the Summary Plan Description, such balance shall be carried over to reimburse the Participant for expenses incurred during a subsequent coverage period.

5.04 Exclusions In addition to those items specifically noted in Section 5.01.B, *supra*, the following is a non-exclusive list of items that are not reimbursable under the terms of this Plan:

- Any item that does not constitute "medical care" as defined under Code § 213(d).
- Automobile insurance premiums.
- Bottled water.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic Surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- Cosmetics, toiletries, toothpaste, etc.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Custodial care.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to an Employee's, Spouse's, or Dependent's inability to perform physical housework).
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- The salary expense of a nurse to care for a healthy newborn at home.
- Uniforms or special clothing, such as maternity clothing.

5.05 Coordination of Benefits Benefits under this Plan are solely intended to reimburse expenses not previously reimbursed or reimbursable elsewhere. In the event that an expense is eligible for reimbursement under both the HRA and a Health FSA see Section III of the Summary Plan Description.

5.06 Reimbursement Procedure

(a) **Timing** Within 30 days after receipt of a reimbursement claim from a Participant, PSA will reimburse the Participant for healthcare expenses (if the claim is approved), or PSA will notify the Participant that his or her claim has been denied. The 30-day period may be extended for an additional 15 days for matters beyond PSA's control, such as situations where a claim is incomplete. PSA will provide written notice of any extension, describing the reasons for the extension and the date by which he or she can expect a decision. Where a claim is incomplete, the extension notice will describe the information still needed by PSA and allow 45 days from receipt of the notice to provide the additional information. If this happens, it will have the effect of suspending any decision on the claim until the specified information is provided.

(b) **Claim Substantiation** In order to obtain reimbursement for healthcare expenses, a Participant shall submit an application in writing to PSA, in such form and in such detail as PSA may prescribe with the following information:

- The amount, date and nature of the expense.
- The name of the individual(s) on whose behalf the expenses have been incurred.
- The name of the person, organization or entity to which the expense was or is to be paid.

- Such other information as PSA may from time to time require.

The Participant must provide a written statement from an independent third party verifying the expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed and are not reimbursable under any other health plan.

This Plan shall reimburse the Participant from the Participant's account for expenses incurred during the plan year while a Participant, and for which the Participant submits documentation in accordance with this Article V. Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses that were incurred before the Effective Date or before the date the Participant commenced participation in this Plan will not be reimbursed.

(c) Denied Claims For reimbursement claims that are denied, see the appeals procedure in Article IX.

(d) Other Reimbursement A Participant shall be entitled at least monthly to seek reimbursement for expenses up to the total amount credited to a Participant's account for the plan year, reduced by prior reimbursements for expenses for the same plan year. For reimbursement claims that are denied, see the appeals procedure in Article 9.02.

(e) Prior Year Expenses As designated in Section III of the Summary Plan Description, an expense incurred during one coverage period may be reimbursed from amounts credited to the active Participant's account in a later coverage period, but only if the Participant was an active Participant during both coverage periods, and other requirements set forth in the Plan and Section III of the Summary Plan Description are satisfied. The Employer may require Participants to follow prescribed procedures (such as resubmission of the expense for reimbursement in a later coverage period) in order to receive reimbursement in the later coverage period.

5.07 Permanent Opt-Out A Participant may elect to permanently opt out of and waive future reimbursements from his or her HRA Account. A Participant who makes that election will not receive reimbursements for any medical care expenses incurred after the opt out election takes effect. Medical care expenses incurred before the opt out election takes effect, however, may be reimbursed during the first Plan Year to which the opt-out election applies so long as no suspension election was in effect for the Plan Year in which such expenses were incurred. If a Participant permanently opts out of this Plan, the Employer will also discontinue contributions to the Participant's HRA Account.

The opportunity to make a permanent opt-out election shall be offered to each Participant at least annually.

5.08 Treatment upon Ceasing to be a Participant Subject to any right mandated by COBRA to elect continuation coverage under the Plan, the following shall apply to Participants who terminate employment or otherwise loses their ability to participate for any reason:

(a) No Additional Contributions Additions or contributions to a Participant's account will end on the day the Participant terminates employment or otherwise loses their ability to participate for any reason.

(b) Runout Period for Expenses Incurred Prior to Termination of Participation Such Participant may receive reimbursement for any expenses incurred during the coverage period prior to termination of participation, provided that the Participant files a claim by the end of the runout period following the termination of participation as elected in Section III of the Summary Plan Description.

(c) No Reimbursement Following Termination of Participation Unless Spend Down is Elected Except to the extent of any spend down feature elected in Section III of the Summary Plan Description and described below, after a Participant severs employment or otherwise ceases to be an eligible Employee for any reason, amounts in the Participant's account will cease to be available for the reimbursement of healthcare expenses of the Participant, the Participant's Spouse and his or her Dependents incurred after the Participant severed employment or ceased to be an eligible Employee. If the Employer elects a spend down feature, then the Plan will reimburse healthcare expenses (as may be redefined for the spend down period) incurred during the period(s) of time (singly or collectively the "spend down period") after the Participant severed employment and/or ceased to be an eligible Employee, in amounts equal to the lesser of (i) the maximum spend down amount specified in Section III of the Summary Plan Description, which may be subject to a vesting schedule as selected in Section III of the Summary Plan Description, or (ii) the balance of the account as of the date the Participant severed employment or ceased to be an eligible Employee, less all other reimbursements from or charges to that account after such date.

(d) Temporary Credit at Start of Credit Period, With Actual Credit on a Daily Basis Through the Credit Period. If selected in Section III of the Summary Plan Description, then amounts credited on a Credit Date are initially only temporarily credited to the active Participant's account on the Credit Date, in anticipation that the active Participant will continue to be an active Participant throughout the Credit Period for which the credit is being made. Amounts temporarily credited on the Credit Date are only actually credited on a daily basis throughout the Credit Period. Accordingly, if a Participant ceases to be an active Participant in the middle of a Credit Period, the amounts not yet actually credited for the Credit Period shall be deemed not credited, and the Participant's account shall be correspondingly reduced (but not below zero). Participants shall not be obligated to repay any reimbursements received from temporarily credited amounts.

5.09 Debit and Credit Cards Participants may, subject to a procedure established by the Employer and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("Cards") provided by the Employer and the Plan for payment of expenses. The stored value is determined by the maximum annual value, subject to the following terms:

(a) Participant Certification Each Participant issued a Card shall certify upon issuance and each plan year thereafter that the card shall only be used for expenses. The Participant shall also certify that any expense paid with the Card has not already been reimbursed by any other plan or source, and that the Participant will not seek reimbursement under any other plan covering health benefits.

(b) Issuance and Revocation of Card Such Card shall be issued upon the Participant's commencement of participation and reissued (or remain active) for coverage periods during which the Participant remains a Participant in the Plan. Such Card shall be automatically cancelled if the Participant dies, terminates employment or otherwise ceases to be an eligible Employee for any reason.

(c) Maximum Expenses Payable with the Card The maximum dollar amount of expenses payable with the Card shall be the maximum dollar amount of coverage available in the Participant's account, or such lesser amount as set forth in Section III of the Summary Plan Description. The Cards shall only be used for the purchase of eligible expenses.

(d) Only Approved Merchants The Cards shall be ineffective (i.e., rejected) except at those merchants and service providers authorized by the Employer. The Employer's authorization of merchants and service providers shall comply with IRS guidance governing the use of Cards, including Rev. Rul. 2003-43, Notice 2006-69, Notice 2007-2, and such superseding or additional guidance as may be promulgated by the IRS.

(e) Substantiation of Expenses All purchases with the Cards must be substantiated by PSA and may be substantiated in any manner allowed by applicable IRS guidance. Without limiting the generality of the preceding sentence, the following rules apply:

(e1) General Rule Except as otherwise allowed by IRS guidance, substantiation will be made by submission of a receipt from a merchant or service provider describing the service or product, the date of the purchase and the amount.

(e2) Co-payment Match Substantiation Method To the extent permitted by IRS guidance, charges shall be considered substantiated if they satisfy the "co-payment match substantiated method" as set forth in Rev. Rul. 2003-43, Notice 2006-69, Notice 2007-2 and superseding or additional IRS guidance. Under that method, a charge is considered substantiated without the need for submission of a receipt or further review if the Group Sponsored Insurance Plan has co-payments in specific dollar amounts, and the dollar amount of the transaction at a health care provider (as identified by its merchant category code), or other merchant/service provider as otherwise allowed by IRS guidance, equals an exact multiple of not more than five times the dollar amount of the co-payment for the specific service (i.e., pharmacy benefit co-payment, co-payment for a physician's office visit, etc.) under the Group Sponsored Insurance Plan covering the specific Participant. In addition, if a health plan has multiple co-payments for the same benefit (e.g., tiered co-payments for a pharmacy benefit), exact matches of multiples or combinations of the co-payments (but not more than the exact multiple of five times the maximum co-payment) will similarly be fully substantiated without the need for submission of a receipt or further review.

(e3) Recurring Expenses To the extent permitted by IRS guidance, charges shall be considered substantiated without the need for submission of a receipt or further review if they match expenses previously approved as to amount, provider and time period (e.g., for a Participant who refills a prescription drug on a regular basis at the same provider for the same amount).

(e4) Real Time Substantiation To the extent permitted by IRS guidance, charges shall be considered substantiated without the need for submission of a receipt or

further review if the merchant, service provider, or other independent third party (e.g., pharmacy benefit manager), at the time and at the point of sale, provides information to verify to PSA (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for an expense.

(e5) Inventory Information Approval System Charges shall be considered substantiated without the need for submission of a receipt or further review if they are made through an "inventory information approval system" as set forth in Section III.B of Notice 2006-69 and additional or superseding IRS guidance.

(e6) Direct Third-Party Substantiation Charges shall be considered substantiated without the need for submission of a receipt or further review by submission of information from an independent third party (such as an "Explanation of Benefits" from an insurance company) indicating the date of the service or product and the Participant's responsibility for payment (e.g., co-insurance payments and amounts below the plan's deductible).

(f) Conditional Until Substantiated: Correction Methods All charges on the Card shall be conditional pending substantiation. If a charge is later determined by PSA not to be an eligible expense, PSA, in its discretion, shall use one or more of the following correction methods to make the Plan whole:

(f1) Repayment of the improper amount by the Participant;

(f2) Claims substitution or offset of future claims until the amount is repaid; and

(f3) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law.

If those corrections prove unsuccessful or are otherwise not available, the Participant shall remain indebted to Employer for the amount of the improper payment. In that event and consistent with its business practices, Employer will treat the payment as it would any other business indebtedness. Until the amount is repaid, PSA shall take further action to ensure that further violations of the terms of the Card do not occur, up to and including denial of access to the Card.

5.10 Compliance with Group Sponsored Insurance Plan Laws Benefits under this Plan shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other laws applicable to group health plans to the extent required by such laws.

ARTICLE VI - Administration

6.01 Plan Administrator (The Employer) The administration of the Plan shall be under the supervision of the Employer. It shall be a principal duty of the Employer to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

6.02 Delegation The Plan Administrator shall have the right to delegate a Third Party Administrator ("TPA") to carry out any and/or all of its responsibilities for control and management of the operation and administration of the Plan. The Employer has designated PacificSource Administrators, Inc. ("PSA") to act as the Third Party Administrator. PSA may resign at any time or may be removed or replaced by the Employer at any time.

6.03 Powers and Duties The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. It shall have the exclusive right to interpret the Plan and to decide all matters and all determinations of the Employer with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Employer shall have the following discretionary authority:

(a) To construe and interpret the provisions of the Plan;

(b) To decide all questions of eligibility and participation, and question of benefits under this Plan;

(c) To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(d) To prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Employer determines to be appropriate;

(e) To request and receive from all Employees and Participants such information as the Employer shall from time to time determine to be necessary for the proper administration of this Plan;

(f) To furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Employer determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's compensation has been reduced in order to provide benefits under this Plan;

(g) To receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Employer deems necessary or appropriate to comply with governmental laws and regulations to the maintenance of records, notifications to Participants, filing with the Internal Revenue Service and U.S. Department of Labor, and all other such requirements applicable to the Plan;

(h) To employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;

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

(j) To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

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

6.04 Reliance on Participant The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant.

6.05 Exclusive Benefit and Uniformity It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. In operating and administering the Plan, the Employer shall apply all rules of procedure and decisions uniformly and consistently, in a nondiscriminatory manner, so that all persons similarly situated will receive substantially the same treatment.

6.06 Third Party Administrator Reliance on Others PSA may rely upon any direction, information or action of a Participant and the Plan Administrator under the Plan and is not required under the Plan to inquire into the propriety of any such direction, information or action. PSA shall be responsible only for the proper exercise of the powers, duties, responsibilities and obligations granted it under the Plan and shall not be responsible for any act or failure to act of the Plan Administrator, Employer or any Employee of the Employer. When adjudicating a claim, PSA shall be entitled to rely upon information furnished by a Participant, the Employer, or the legal counsel of the Employer.

6.07 Required Information to be Furnished Each Participant and Beneficiary will furnish to the Plan Administrator such information as the Employer considers necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Participant or Beneficiary of such true, full and complete information as the Employer may request. Any communication, statement or notice to a Participant and Beneficiary addressed to the last post office address filed with the Employer, or if no such address was filed with the Employer, then to the last post office address of the Participant or Beneficiary as shown on the Employer's records, will be binding on the Participant or Beneficiary for all purposes of this Plan and neither the Employer or PSA shall be obliged to search for or ascertain the whereabouts of any Participant or Beneficiary.

6.08 Indemnification of the Third Party Administrator and Plan Administrator PSA shall be indemnified by the Plan Administrator against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim relating thereto.

6.09 Expenses of Administration The usual and reasonable expenses of PSA shall be

paid by the Employer or the Participant, and any expenses not paid by the Employer or the Participant shall not be the responsibility of PSA.

6.10 Named Fiduciary The Employer is the named fiduciary for the Plan for purposes of ERISA Section 402(a). The fiduciary shall be bonded to the extent required by ERISA.

6.11 Insurance Contracts The Employer shall have the right to: (a) enter into a contract with one or more insurance companies for the purpose of providing any benefits under the Plan, on any terms and conditions it may choose in its sole discretion; and (b) replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

6.12 Inability to Locate Payee If PSA is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

6.13 Effect of Mistake In the event of a mistake as to the eligibility or participation of an Employee, the Employer or PSA shall to the extent that it deems administratively possible affect such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action may include withholding of any amounts due to the Plan or the Employer from compensation paid by the Employer.

ARTICLE VII - General Provisions

7.01 Amendment or Termination of the Plan The Employer has established the Plan with the intention and expectation that it will be continued, but the Employer will have no obligation to maintain the Plan, and the Employer may terminate all or any part of this Plan at any time hereafter without liability. Upon termination of the Plan, all elections and reductions in compensation relating to the Plan shall terminate, and reimbursements shall be made as if all Employees had terminated employment. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business.

7.02 Governing Law The Plan shall be construed, administered and enforced in accordance with law of the State where the Employer is headquartered, to the extent not superseded by the Code, ERISA, or any other federal law.

7.03 Code and ERISA Compliance It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this 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 this Plan shall be deemed superseded to the extent of the conflict.

To the extent applicable, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, including USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, GINA, and PPACA.

7.04 Indemnification of the Plan Administrator If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

7.05 No Guarantee of Tax Consequences The Employer makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income 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 and to notify the Employer if the Participant has any reason to believe that such payment is not so excludable.

If a Participant receives a reimbursement and it is later determined that the payment was made in error (e.g., reimbursement for an expense that is later paid by an insurance plan), the Participant will be required to refund the improper payment to the Plan. If the refund is not received for the improper payment, the Plan reserves the right to offset future reimbursement equal to the improper payment or, if that is not feasible, to withhold such funds from his or her pay. If all other attempts to recoup the improper payment are unsuccessful, the Employer may treat the overpayment as a bad debt, which may have income tax consequences to the Participant.

7.06 No Contract of Employment Nothing herein contained is intended to be or shall be

construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

7.07 Limitation of Rights Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Employee or other person any legal or equitable right against PSA or the Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Employee be modified or in any way be affected hereby.

7.08 Non-Assignability of Rights The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

7.09 Titles for Convenience Only The headings of the Articles of this Plan are inserted for convenience only and shall not be deemed to constitute a part of this Plan nor used in the interpretation or construction thereof.

7.10 Severability If any provision of the Plan is declared invalid or unenforceable, such provision will not affect the remainder of the Plan which shall be construed as if such provision had not been inserted.

7.11 Substantiation Every expense incurred by an Employee under a qualified benefit during the plan year is subject to the substantiation rules in accordance with Section 105.

ARTICLE VIII - HIPAA Provisions

8.01 Adequate Separation Between Plan and Employer The Employer shall allow the following persons access to Protected Health Information (PHI):

(a) Privacy Official;
(b) Employees in the Employer's Human Resources Department;
(c) Employees in the Employer's Office of General Counsel; and
(d) Any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the Plan (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals).

No other persons shall have access to PHI. These specified Employees (or classes of Employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that any of these specified Employees does not comply with the provisions of this section, that Employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's Employee discipline and termination procedures. The Employer will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

When this health information is provided from the Health HRA to the Employer, it is PHI. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article.

PHI means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased. The Employer shall have access to PHI from the HRA only as permitted under this Article or as otherwise required or permitted by HIPAA.

The Health Information Technology for Economic and Clinical Health Act passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff."

8.02 Permitted Disclosure of Enrollment/Disenrollment Information The Plan may disclose to the Employer information on whether the individual is participating in the Plan.

8.03 Permitted Uses and Disclosure of Summary Health Information The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided

health benefits under a health plan; and (b) from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

8.04 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes Unless otherwise permitted by law, the Plan may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. "plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by Employer of a Covered Individual's PHI will be subject to and consistent with the provisions of this Article (including, but not limited to, the restrictions on the Employer's use and disclosure described in Section 7.5) and the specifications and requirements of the administrative simplification provisions of HIPAA and its implementing regulations at 45 CFR Parts 160-64.

8.05 Conditions of Disclosure for Plan Administration Purposes The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health FSA, the Employer shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required in 45 CFR Section 504(f)(2)(iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic

PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the Plan any security incident of which it becomes aware.

8.06 Certification of Plan Sponsor The Plan shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Article 8.05.

ARTICLE IX - Appeals Procedure

9.01 Procedure if Benefits are Denied under this Plan If a claim for reimbursement or benefit under this Plan is wholly or partially denied, such claim shall be administered in accordance with the procedure set forth below and in the Summary Plan Description of this Plan. The Appeals Committee, separate and distinct from the individual(s) that adjudicate the claims, shall act on behalf of the Employer with respect to appeals. An external review process shall be provided as legally required and as further set forth below.

If PSA denies a claim, in whole or in part, the Employee will be notified in writing within 30 days of the date PSA receives the claim. The 30-day period may be extended for an additional 15 days for matters beyond PSA's control, such as situations where a claim is incomplete. PSA will provide written notice of any extension, describing the reasons for the extension and the date by which he or she can expect a decision. Where a claim is incomplete, the extension notice will describe the information still needed by PSA and allow 45 days from receipt of the notice to provide the additional information. If this happens, it will have the effect of suspending any decision on the claim until the specified information is provided.

If PSA denies a claim, the Employee will receive a notice that includes the following elements:

- The specific reason or reasons for the denial;
- The specific Plan provision or provisions that support the denial;
- A description of any items or information the Employee would need to validate the claim and an explanation of why the added material is necessary; and
- A description of the steps to appeal the denial, including the Employee's right to submit written comments, his or her right to review (upon request and at no charge) relevant documents and other information, and the Employee's right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of the claim.

9.02 Appeals The Employee may appeal a claim denial by submitting a Request for Review (or other written appeal request) to PSA within 180 days of the date of notice of the claim denial. If the Employee does not appeal on time, he or she will lose the right to appeal the denial and the right to file suit in court. The written appeal should state the reasons that he or she feels the claim should not have been denied, and should include any additional items or information that he or she feels supports the claim. The appeal process will provide the Employee with the opportunity to ask additional questions and make written comments, and he or she may review (upon request and at no charge) documents and other information relevant to the appeal.

To the extent a dispute arises under the terms of one of the insurance plans, such as a group medical or dental insurance plan offered by the Employer, the ability to appeal decisions under the insurance plan will be outlined in the Summary Plan Description or similar explanatory booklet available from the insurer.

9.03 Decision on Review PSA will review the Employee's appeal within 60 days after receiving the request. PSA may, in its discretion, hold a hearing on the denied claim. If PSA consults with a medical expert to help analyze the appeal, the expert will be different from, and not subordinate to, any expert that was consulted in connection with the initial claim denial. If upon review a decision is reached to affirm the original denial of the claim, the Employee will receive a notice of that determination, which will include the following elements:

(a) The specific reason or reasons for the decision on review;

(b) The specific Plan provision or provisions that motivated the decision;

(c) A statement of the Employee's right to review (upon request and at no charge) relevant documents and other information;

(d) If "internal rules, guidelines, protocols, or other similar criteria" (collectively referred to as "internal guidelines") are relied on in making the decision on review, a description of the specific internal guidelines, or a statement that such internal guidelines were relied on, and a copy of the internal guidelines will be provided free of charge to the Employee upon request; and

(e) A statement of the Employee's right to bring suit under ERISA Section 502(a) (where applicable).

* * *

This document is executed on this 25 day of March, 2022.

City of Springfield

By: _____

Title: 3-25-2022