ADOPTION AGREEMENT
HEALTH REIMBURSEMENT PLAN

The undersigned adopting employer hereby adopts this Plan. The Plan is intended to qualify as a health reimbursement arrangement under Code sections 106 and 105. The Plan shall consist of this Adoption Agreement, its related Basic Plan Document and any related Appendix and Addendum to the Adoption Agreement. Unless otherwise indicated, all Section references are to Sections in the Basic Plan Document.

COMPANY INFORMATION

1. Name of adopting employer (Plan Sponsor): **Town of Seabrook**
2. Address: **P.O. Box 456**
3. City: **Seabrook** **4.**State: **NH** **5.** Zip: **03874**
6. Phone number: **603-474-8025** **7.** Fax number: **603-474-8007**
8. Plan Sponsor EIN: **02-6000833**
9. Plan Sponsor fiscal year end: **12/31**
10a. Plan Sponsor entity type:
- **i.** [ ] C Corporation
- **ii.** [ ] S Corporation
- **iii.** [ ] Non Profit Organization
- **iv.** [ ] Partnership
- **v.** [ ] Limited Liability Company
- **vi.** [ ] Limited Liability Partnership
- **vii.** [ ] Sole Proprietorship
- **viii.** [ ] Union
- **ix.** [**X**] Government Agency
- **x.** [ ] Other: _____

10b. If **10a.viii** (Union) is selected, enter name of the representative of the parties who established or maintain the Plan: _____
11. State of organization of Plan Sponsor: **New Hampshire**
12a. The Plan Sponsor is a member of an affiliated service group:
[ ] Yes [**X**] No
12b. If **12a** is "Yes", list all members of the group (other than the Plan Sponsor): _____
13a. The Plan Sponsor is a member of a controlled group:
[ ] Yes [**X**] No
13b. If **13a** is "Yes", list all members of the group (other than the Plan Sponsor): _____

PLAN INFORMATION

A. **GENERAL INFORMATION.**

1. **Plan Number:** 502
2. **Plan name:** a. **Town of Seabrook**
   b. **Health Reimbursement arrangement**
3. **Effective Date:**

3a. Original effective date of Plan: **06/01/2012**

3b. Is this a restatement of a previously-adopted plan:
[X] Yes [ ] No

3c. If **A.3b** is "Yes", effective date of Plan restatement: **01/01/2020**.
NOTE: If **A.3b** is "No", the Effective Date shall be the date specified in **A.3a**, otherwise the date specified in **A.3c**; provided, however, that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.

4a. **Plan Year** means each 12-consecutive month period ending on **12/31** (e.g. December 31). If the Plan Year changes, any special provisions regarding a short Plan Year should be placed in the Addendum to the Adoption Agreement.

4b. The Plan has a short plan year:
[ ] Yes [X] No

4c. If **A.4b** is "Yes", the short plan year begins _____ and ends on _____.

5. Is the Plan Subject to ERISA?
[ ] Yes [X] No

B. **ELIGIBILITY.**

Other Company Benefit Plan

1a. An Employee is eligible to participate in the Plan under the same terms and conditions as under the Company benefit plan(s) specified in **B.1b**:
   i. [X] Yes - without limitation
   ii. [ ] Yes - with limitations and modifications described in **B.1c**
   iii. [ ] No

1b. If B.1a is not "No", enter name of other Company benefit plan(s): **Anthem BCBS NH Lumenos 2500 Plan**.

1c. If **B.1a** is " Yes - with limitations and modifications", describe limitations and/or modifications:
_____.

NOTE: If **B.1a** is not "No", the remainder of Section **B** is disregarded.

Exclusions/Modifications

If **B.1a** is "No", the term "Eligible Employee" shall not include (Check items **B.2 - B.6a** as appropriate):

2. [ ] **Union.** Any Employee who is included in a unit of Employees covered by a collective bargaining agreement, if benefits were the subject of good faith bargaining, and if the collective bargaining agreement does not provide for participation in this Plan.
3. [ ] Any **leased employee**.
4. [ ] **Non-Resident Alien.** Any Employee who is a non-resident alien who received no earned income (within the meaning of Code section 911(d)(2)) which constitutes income from services performed within the United States (within the meaning of Code section 861(a)(3)).
5. [ ] **Part-time.** Any Employee who is expected to work less than _____ hours per week.

6a. [ ] **Other.** Other Employees described in **B.6b**.

6b. If **B.1a** is "No", and **B.6a** is selected, describe other Employees excluded from definition of Eligible Employee: _____.

NOTE: The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 105(h)(5)) as to benefits provided or eligibility to participate.

7a. If **B.1a** is "No", allow immediate participation for all Eligible Employees employed on the date specified in **B.7b**:

[ ] Yes [ ] No

7b. If **B.1a** is "No" and **B.7a** is "Yes", all Eligible Employees employed on _____ shall become eligible to participate in the Plan as of such date.

8a. If **B.1a** is "No", indicate whether the Plan will make any other revisions to the term "Eligible Employee":

[ ] Yes [ ] No

8b. If **B.1a** is "No" and **B.8a** is "Yes", describe any further modifications to the term "Eligible Employee": _____.

Service Requirements

10. If **B.1a** is "No", minimum age requirement for an Eligible Employee to become eligible to be a Participant in the Plan: _____
11. If **B.1a** is "No", minimum service requirement for an Eligible Employee to become eligible to be a Participant in the Plan:
    i. [ ] None.
    ii. [ ] Completion of _____ hours of service.

iii. [ ] Completion of _____ days of service.

iv. [ ] Completion of _____ months of service.

v. [ ] Completion of _____ years of service.

12a. If **B.1a** is "No", frequency of entry dates:

i. [ ] An Eligible Employee shall become a Participant in the Plan as soon as administratively feasible upon meeting the requirements of **B.10** and **B.11**.

ii. [ ] first day of each calendar month.

iii. [ ] first day of each plan quarter.

iv. [ ] first day of the first month and seventh month of the Plan Year.

v. [ ] first day of the Plan Year.

12b. If **B.1a** is "No" and **B.12.a.i** (immediate entry) is not selected, an Eligible Employee shall become a Participant in the Plan on the entry date selected in **B.12a** that is:

i. [ ] coincident with or next following

ii. [ ] next following

the date the requirements of **B.10** and **B.11** are met.

13a. If **B.1a** is "No", indicate whether the Plan will make any other revisions to the eligibility rules specified in **B.10 - B.12**:

[ ] Yes [ ] No

13b. If **B.1a** is "No" and **B.13a** is "Yes", describe any further modifications to the eligibility rules specified in **B.10 - B.12**: _____.

Former Employees

15a. Permit Eligible Employees to participate in the Plan after Termination (Section 3.03; See item **C.10** to describe benefits available to former employees):

i. [ ] Yes - all Eligible Employees are eligible to participate in the Plan after Termination.

ii. [ ] Yes - selected Eligible Employees are eligible to participate in the Plan after Termination.

iii. [X] No.

15b. If **B.15a** is "Yes - selected Eligible Employees are eligible to participate in the Plan after Termination", describe the Employees: _____.

NOTE: The election in **B.15** does not have an effect on COBRA coverage.

C. BENEFITS

Eligible Expenses

1a. Coverage under the Plan for Covered Persons is available for the following Eligible Expenses (Section 4.01):

i. [ ] **All allowable medical expenses.** All medical expenses that are excludable from income under Code section 105(b).

ii. [X] **Listed medical expenses.** All medical expenses that are listed on an appendix to the Adoption Agreement and that are excludable from income under Code section 105(b).

iii. [ ] **Health plan deductibles.** Only health plan deductible amounts that are otherwise payable by the Participant under a Company-sponsored medical plan covering the Participant.

iv. [ ] **Health plan coinsurance.** Only health plan coinsurance amounts that are otherwise payable by the Participant under a Company-sponsored medical plan covering the Participant.

v. [ ] **Health plan deductibles and coinsurance.** Only health plan deductibles and coinsurance amounts that are otherwise payable by the Participant under a Company-sponsored medical plan covering the Participant.

vi. [ ] **Schedule of expenses.** A schedule of allowable medical expenses under a Company-sponsored medical plan(s) (current or former) as provided in an appendix to the Adoption Agreement.

NOTE: If **C.1a.vi.** is selected, the terms listed in the schedule of expenses shall be defined as provided in the relevant Company-sponsored medical plan.

1b. Are there any other modifications to the definition of Eligible Expenses:
[ ] Yes [X] No

1c. If **C.1b** is "Yes", describe modifications to the definition of Eligible Expenses: _____.
NOTE: The modifications listed in **C.1c** may not be inconsistent with expenses that are excludable from income under Code section 105(b).

Covered Person

2a. The definition of Covered Person under the Plan shall include the following persons:

i. [ ] **Participant, spouse and dependents.** The Participant, his or her spouse and all dependents within the meaning of Code section 152 as modified by Code section 105(b), and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday.

ii. [X] **Persons covered under Company medical plan.** The Participant, his or her spouse and all dependents within the meaning of Code section 152 as modified by Code section 105(b), and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday, but only if such persons are also covered under the Company-sponsored benefit plan specified in **C.2b.**

iii. [ ] **Participants Only.** No spousal or dependent coverage.

iv. [ ] **Other.** The persons described in **C.2c.**

NOTE: The Plan Administrator may extend coverage for children until the end of the calendar year in which a child turns age 26.

2b. If **C.2a** is "Persons covered under Company medical plan", indicate the name of the Company-sponsored benefit plan: **Anthem BCBS NH Lumenos 2500 Plan**.

NOTE: If i) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, ii) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act, and iii) children are covered under this Plan, all children up to their 26th birthday must be covered.

2c. If **C.2a** is "Other", indicate the definition of Covered Person: _____.

NOTE: The definition in **C.2c** may not include anyone other than the Participant, his or her spouse and all dependents within the meaning of Code section 152 as modified by Code section 105(b), and any child (as defined in section 152(f)(1)) of the Participant until his or her 26th birthday. If i) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, ii) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act, and iii) children are covered under this Plan, all children up to their 26th birthday must be covered.

Health Reimbursement Account - Maximum Benefit

3a. If **C.1a.vi** is selected are the maximum annual amounts specified in the schedule of benefits?

[ ] Yes [ ] No

NOTE: If the maximum annual amount credited to a Participant's Health Reimbursement Account depends on the Company-sponsored benefit plan the Participant is enrolled in or the particular type of Eligible Expense, **C.1a.vi** (schedule of expenses) should be selected and **C.3a** should be "Yes" (the maximum annual amounts entered in the schedule of benefits apply to this Plan).

3b. Enter the maximum annual amount that will be credited to a Participant's Health Reimbursement Account in any Plan Year for the applicable coverage category (Section 4.01):

i. One Covered Person (Participant only): **See Appendix A**

ii. Two Covered Persons (Participant plus one other Covered Person): **See Appendix A**

iii. More than two Covered Persons (Family coverage): **See Appendix A**

NOTE: If the Plan only provides for a single coverage level for all Participants, enter that coverage level in **C.3b.i.**- **C.3b.iii.**

NOTE: The maximum annual amount is determined after any deductibles and coinsurance are calculated. For example, if the HRA pays the last $750 of a $1,000 plan deductible (after the Participant pays $250), **C.3b.i** should be "$750".

3c. **FSA Failsafe**. Limit the maximum annual benefit to 5 times the value of coverage and exclude long term care services:

[ ] Yes [X] No

NOTE: If **C.3c** is "Yes", the Plan is intended to be a flexible spending arrangement under Code section 106(c). Qualified long term care services as defined in Code section 7702B(c) are not an Eligible Expense under the plan and the maximum amount of reimbursement available must be less than 5 times the value of such coverage.

Health Reimbursement Account - Deductible

4. Enter the annual Health Reimbursement Account deductible in any Plan Year for the applicable coverage category:

   a. One Covered Person (Participant only): $**See Appendix A**

   b. Two Covered Persons (Participant plus one other Covered Person): $**See Appendix A**

   c. More than two Covered Persons (Family coverage): $**See Appendix A**

   NOTE: If the Plan only provides for a single deductible for all Participants, enter that coverage level in **C.4a**.- **C.4c**.

   NOTE: If the Participants are also covered by a Company-sponsored medical plan, enter the deductible that applies to this plan (the Health Reimbursement Plan), ***not*** the deductibles of the Company-sponsored plan. Any expenses covered by a Company-sponsored plan are not an Eligible Expense under this Plan (Section 4.01(c)).

   NOTE: If **C.1a.vi** (schedule of benefits) is selected, enter 0 (zero) if no annual deductible applies before the schedule of benefits is implemented.

   NOTE: If i) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and ii) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act, then the Plan must provide coverage without cost-sharing requirements for preventative care to the extent required under Treas. Reg. 54.9815-2713T (and any superseding guidance; up to the amount available under a Participant's Health Reimbursement Account).

Health Reimbursement Account - Coinsurance

5. If **C.1a.vi** is not selected, once the HRA deductible is met (if any), indicate the level of coverage provided under the HRA until the annual amount under **C.3** is met: _____ (for example, "50% of coinsurance/copayment amounts" or "100% of Eligible Expenses").

   NOTE: If **C.5** is left blank, once the HRA deductible is met (if any), the Plan will provide coverage for 100% of Eligible Expenses until the annual amount under **C.3** is met, unless otherwise provided in the Adoption Agreement.

NOTE: If i) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and ii) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act, then the Plan must provide coverage without cost-sharing requirements for preventative care to the extent required under Treas. Reg. 54.9815-2713T (and any superseding guidance; up to the amount available under a Participant's Health Reimbursement Account).

Health Reimbursement Account - Procedures

6a. The amounts in **C.3** shall be credited to the Participant's Health Reimbursement Account at the following times:

- **i.** [ ] **Beginning of Plan Year**. The entire amount shall be credited at the beginning of the Plan Year.
- **ii.** [ ] **Semi annually**. One half of the amount shall be credited at the beginning of the Plan Year and on the first day of the seventh month of the Plan Year.
- **iii.** [ ] **Quarterly**. One fourth of the amount shall be credited at the beginning of each plan quarter.
- **iv.** [ ] **Monthly**. One twelfth of the amount shall be credited at the beginning of each calendar month during the Plan Year.
- **v.** [ ] **Per payroll period**. Amounts are credited each payroll period in an amount equal to the entire amount divided by the number of payroll periods.
- **vi.** [X] **Claims dependent**. Accounts are credited and reimbursements are made as claims are made.

6b. If **C.6a.vi** is not selected and a Participant enters the Plan at a time other than the beginning of a period described in **C.6a**, the amounts credited to the Participant's Health Reimbursement Account for such period shall be reduced to reflect the time of actual participation in the applicable period:

[ ] Yes [ ] No

6c. If **C.6a.vi** is not selected and if a change to the number of Covered Persons under **C.2** affects the amount(s) credited to the Health Reimbursement Account at times other than that selected in **C.6a**, contributions to the Participant's Health Reimbursement Account will be prorated to accommodate the change:

[ ] Yes [ ] No - only future contributions affected

NOTE: If you select "Yes", this may result in a forfeiture from a Participant's Account, or, if amounts have been credited from a Participant's Account in excess of prorated amounts, future contributions may be discontinued until the correct contribution amount is attained.

7a. The Plan allows a carryover of the balance in a Participant's Health Reimbursement Account to the next Plan Year:

i. [ ] Yes.

ii. [ ] Yes - but limited to the dollar amount specified in **C.7b**.

iii. [ ] Yes - but limited to the multiple specified in **C.7b** of the maximum annual benefit specified in **C.3**.

iv. [**X**] No.

7b. If **C.7a** is "Yes with limitations", enter the maximum dollar amount (or multiple of the maximum annual amount specified in **C.3**) that may be carried over to the next Plan Year: _____.
NOTE: Enter a percentage if **C.7a.iii** is selected and the multiple is less than 1.

Coordination with Other Plans

8. Describe method to coordinate coverage in the Plan with a Health Care Reimbursement Account ("HCRA") in a Company-sponsored cafeteria plan for expenses that are reimbursable under both this Plan and the cafeteria plan (Section 6.01(e)):

i. [**X**] **None**. Plan is not used in conjunction with a Company-sponsored HCRA.

ii. [ ] **HRA first**. A Participant shall not be entitled to payment/reimbursement under the HCRA until the Participant has received his or her maximum reimbursement under the Plan.

iii. [ ] **Cafeteria plan first**. A Participant shall not be entitled to payment/reimbursement under this Plan until the Participant has received his or her maximum reimbursement under the HCRA.

9a. Describe method to coordinate coverage in the Plan with Health Savings Accounts (Section 6.01(j)):

i. [**X**] **None**. Coverage in the Plan is not limited or the Plan is not used in conjunction with a Health Savings Account.

ii. [ ] **Permitted Coverage**. Coverage in the Plan is only provided for permitted insurance and other specified coverage (e.g., coverage for accidents, disability, dental care, vision care or preventive care within the meaning of Code section 223(c)(1), Rev. Rul. 2004-45 and Notice 2008-59).

iii. [ ] **Post Deductible Coverage**. The Plan will not pay or reimburse any medical expense incurred before the minimum annual deductible under Code section 223(c)(2)(A)(i) is satisfied pursuant to Notice 2008-59.

iv. [ ] **Both Permitted and Post Deductible Coverage**. Until the minimum annual deductible under Code section 223(c)(2)(A)(i) is satisfied, coverage in the Plan is only provided for permitted insurance and other specified coverage (e.g., coverage for accidents, disability, dental care, vision care or preventive care within the meaning of Code section 223(c)(1) and Rev. Rul. 2004-45). The Plan will pay or reimburse all medical expenses otherwise allowed by the Plan incurred after the minimum annual deductible under Code section 223(c)(2)(A)(i) is satisfied.

v. [ ] **Suspended HRA**. A Participant may elect to forego coverage in the Plan except for permitted insurance and other specified coverage (e.g., coverage for accidents, disability, dental care, vision care or preventive care within the meaning of Code section 223(c)(1) and permitted by Rev. Rul. 2004-45).

9b. If **C.9a** is not "None", the limitations shall apply to:

i. [ ] All Participants.

ii. [ ] Only Participants who are also eligible to participate in the high deductible health plan.

iii. [ ] Only Participants who are also enrolled in the high deductible health plan.

NOTE: If **C.9a** is "None" or **C.9b** is not "All Participants", eligibility for a Health Savings Account may be limited.

Former Employees

10a. If **B.15a** is "Yes" (Eligible Employees may participate in the Plan after Termination), select what benefits the Employees described in **B.15** are eligible for after Termination:

i. [ ] Plan Year spend-down. Former employees may spend down the amount remaining in their Account through the end of the Plan Year or 90 days after Termination, whichever is later.

ii. [ ] Other. As specified in **C.10b.**

NOTE: If **C.10a.i** is selected, no new benefits will apply to Terminated participants. If you want to provide new benefits for Terminated Participants or other spend-down periods, select **C.10a.ii** and indicate what benefits Terminated Participants will receive and any restrictions on Eligible Expenses in **C.10b.**

10b. If **C.10a.ii** is selected, describe any unique Plan features that apply to the Employees described in **B.15**: _____.

NOTE: The elections in **C.10** will apply irrespective of whether employees are eligible for or elect COBRA coverage.

NOTE: Unless otherwise specified in **C.10b**, Eligible Expenses, benefits and other Plan provisions will apply in the same manner to former employees as other Plan Participants.

D. PLAN OPERATIONS

Claims

1. Claims for reimbursement for an active Participant must be filed with the Plan Administrator (Section 6.01):

i. [**X**] within 90 days following the last day of each Plan Year.

ii. [ ] by _____.

2a. The Plan provides for an earlier deadline for claims submission for Terminated Participants:
[X] Yes [ ] No

2b. If **D.2a** is Yes, claims for reimbursement for a Terminated Participant must be filed with the Plan Administrator (Section 6.01):

i. [X] within 90 days following Termination of employment.

ii. [ ] by _____.

3. Indicate whether the Company will provide debit, credit, and/or other stored-value cards (Section 6.01(i)):
[X] Yes [ ] No

Plan Administrator

4a. Designation of Plan Administrator (Section 7.01):

i. [X] Plan Sponsor

ii. [ ] Committee appointed by Plan Sponsor

iii. [ ] Other

4b. If **D.4a.iii** is selected, Name of Plan Administrator: _____

5a. Type of indemnification for the Plan Administrator (Section 7.02):

i. [ ] None - the Company will not indemnify the Plan Administrator.

ii. [X] Standard as provided in Section 7.02.

iii. [ ] Custom.

5b. If **D.5a.iii** (Custom) is selected, indemnification for the Plan Administrator is provided pursuant to an Addendum to the Adoption Agreement.

State Law Rules

10a. If **A.5** is "No" (non-ERISA Plan), is the Plan subject to other state law rules?:
[ ] Yes [X] No

10b. If **A.5** is "No" (non-ERISA Plan) and **D.10a** is "Yes", enter any State law rules that apply to the Plan: _____.

E. EFFECTIVE DATES

Use this Section to provide any effective dates for Plan provisions other than the Effective Date specified in **A.3**.

F. EXECUTION PAGE

Failure to properly fill out the Adoption Agreement may result in the failure of the Plan to achieve its intended tax consequences.

The Plan shall consist of this Adoption Agreement, its related Basic Plan Document #HRA and any related Appendix and Addendum to the Adoption Agreement.

Additional participating employers may be specified in an addendum to the Adoption Agreement.

The undersigned agree to be bound by the terms of this Adoption Agreement and Basic Plan Document and acknowledge receipt of same.

The Plan Sponsor caused this Plan to be executed this _____ day of _____, 2020.

TOWN OF SEABROOK:

Signature:_____

Print Name: _____

Title/Position:_____

APPENDIX A

The following are available for coverage under this Plan (but only if also excludable from income under Code section 105(b)):

Medical Deductible and RX Deductible are eligible expenses.HRA FireHRA will reimburse the first $2,150/$4,300Participant is responsible for last $350/$700HRA SSEAHRA will reimburse the first: $2,000/$4,500Participant is responsible for last: $500/$500HRA SSEA Post 4/1/19* (Participant must submit manual claims to meet deductible)Participant is responsible for first: $2,500/$2,500HRA will then reimburse the last: $0/$2,500HRA SEA Post 4/1/15* (Participant must submit manual claims to meet deductible)Participant is responsible for first: $1,850/$2,500HRA will then reimburse the last: $650/$2,500HRA 100%HRA will reimburse 100% $2,500/$5,000

TOWN OF SEABROOK
FORMAL RECORD OF ACTION

The following is a formal record of action taken by the governing body of Town of Seabrook (the "Company").

With respect to the amendment and restatement of the Town of Seabrook Health Reimbursement arrangement (the "Plan"), the following resolutions are hereby adopted:

RESOLVED: That the Plan be amended and restated in the form attached hereto, which Plan is hereby adopted and approved;

RESOLVED FURTHER: That the appropriate officers of the Company be, and they hereby are, authorized and directed to execute the Plan on behalf of the Company;

RESOLVED FURTHER: That the officers of the Company be, and they hereby are, authorized and directed to take any and all actions and execute and deliver such documents as they may deem necessary, appropriate or convenient to effect the foregoing resolutions including, without limitation, causing to be prepared and filed such reports, documents or other information as may be required under applicable law.

Dated this _____ day of _____, 2020.

_____

_____

_____

HEALTH REIMBURSEMENT PLAN
BASIC PLAN DOCUMENT #HRA

HEALTH REIMBURSEMENT PLAN
BASIC PLAN DOCUMENT
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ARTICLE 1
INTRODUCTION

Section 1.01 PLAN

This document ("Basic Plan Document") and its related Adoption Agreement are intended to qualify as a health reimbursement arrangement that provides benefits that are excludable from gross income under Code section 105(b) and shall be administered in accordance with IRS Notice 2002-45 and IRS Revenue Ruling 2002-41.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Company on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Company whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan, as in effect from time to time prior to that date.

ARTICLE 2
DEFINITIONS

"Adoption Agreement" means the document executed in conjunction with this Basic Plan Document that contains the optional features selected by the Plan Sponsor.

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

"Company" means the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

"Covered Person" shall have the meaning set forth in the Adoption Agreement.

"Effective Date" shall have the meaning set forth in the Adoption Agreement.

"Eligible Employee" means any Employee employed by the Company, subject to the modifications and exclusions described in the Adoption Agreement. 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 the Company is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Company 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.

An individual who becomes employed by the Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the trade or business shall not become eligible to participate in the Plan until the Plan Sponsor specifically authorizes such participation.

"Eligible Expenses" shall have the meaning set forth in the Adoption Agreement.

"Employee" means any individual who is employed by the Employer. 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 of an S corporation.

"Employer" means the Company or any other employer required to be aggregated with the Company under Code sections 414(b), (c), (m) or (o); provided, however, that "Employer" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

"Health Reimbursement Account" means the balance of a hypothetical account established pursuant to Section 4.01 for each Participant as of the applicable date and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

"Participant" means an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

"Plan Administrator" means the person(s) designated pursuant to the Adoption Agreement and Section 7.01.

"Plan Sponsor" means the entity described in the Adoption Agreement.

"Plan Year" means the 12-consecutive month period described in the Adoption Agreement.

"Termination" and "Termination of Employment" means any absence from service that ends the employment of the Employee with the Company.

ARTICLE 3
PARTICIPATION

Section 3.01 PARTICIPATION

Each Eligible Employee as of the Effective Date who was eligible to participate in the Plan immediately prior to the Effective Date shall be a Participant eligible to participate in the Plan pursuant to Article 4 on the Effective Date. Each other Eligible Employee who was not a Participant in the Plan prior to the Effective Date shall become a Participant eligible to participate pursuant to Article 4 on the date specified in the Adoption Agreement; provided that he is an Eligible Employee on such date.

Section 3.02 TRANSFERS

If a change in job classification or a transfer results in an individual no longer qualifying as an Eligible Employee, such Employee shall cease to be a Participant for purposes of Article 4 (or shall not become eligible to become a Participant) as of the effective date of such change of job classification or transfer. Should such Employee again qualify as an Eligible Employee or if an Employee who was not previously an Eligible Employee becomes an Eligible Employee, he shall become a Participant on the first entry date following the later of the effective date of such subsequent change of status or the date the Employee meets the eligibility requirements of this Article 3.

Section 3.03 TERMINATION AND REHIRES

If an Employee has a Termination of Employment, such Employee shall not become eligible to become a Participant as of his Termination of Employment. In addition, unless otherwise specified in the Adoption Agreement, if an Employee has a Termination of Employment, such Employee shall cease to be a Participant for purposes of Article 4 as of his Termination of Employment. If the Adoption Agreement permits Eligible Employees to participate in the Plan after Termination, former employees will continue to be eligible to participate in the Plan until such time and with the benefits specified in the Adoption Agreement.

An individual who has satisfied the applicable eligibility requirements set forth in Article 3 as of his Termination date, and who is subsequently reemployed by the Company as an Eligible Employee, shall resume or become a Participant on the first entry date following his rehire date. An individual who has not so qualified for participation on his Termination date, and who is subsequently reemployed by the Company as an Eligible Employee, shall be eligible to participate on the first entry date following the later of the effective date of such reemployment or the date the individual meets the eligibility requirements of this Article 3.

Section 3.04 PROCEDURES FOR ADMISSION

The Plan Administrator shall prescribe such forms and may require such data from Participants as are reasonably required to enroll a Participant in the Plan or to effectuate any Participant elections. The Plan Administrator may impose other limitations and/or conditions with respect to participation in the Plan on Eligible Employees who commence or recommence participation in the Plan pursuant to Sections 3.02 and 3.03.

ARTICLE 4
ACCOUNTS

Section 4.01 HEALTH REIMBURSEMENT ACCOUNTS

(a) Credits. Each Participant's Health Reimbursement Account shall be credited each Plan Year with the maximum annual amount specified in the Adoption Agreement for each coverage level, unless the Adoption Agreement provides that a portion of such annual amount shall be credited periodically throughout the Plan Year.

(b) Debits. Each Participant's Health Reimbursement Account shall be debited for Eligible Expenses described in Subsection (c).

(c) Eligible Expenses. A Participant may be reimbursed from his or her Health Reimbursement Account for Eligible Expenses incurred by Covered Persons provided such expenses are (i) incurred in the Plan Year, (ii) incurred while the Participant participates in the Plan, (iii) not attributable to a deduction allowed under Code section 213 for any prior taxable year, and (iv) not covered, paid or reimbursed from any other source. For purposes of Code section 105(b), dependents shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.

Section 4.02 FORFEITURES/TRANSFERS

(a) Forfeitures. Except as provided in Subsection (b) and (c), any balance remaining in a Participant's Health Reimbursement Account after the end of any Plan Year shall be forfeited and shall remain the property of the Company. Except as expressly provided herein, any balance remaining in a Participant's Account on his date of Termination shall be forfeited and shall remain the property of the Company. However, no forfeiture (or carryover permitted in Subsection (b)) shall occur until all payments and reimbursements hereunder have been made on claims submitted within the time period specified in Section 6.01(b).

(b) Carryovers. To the extent permitted in the Adoption Agreement and subject to any conditions and/or limitations in the Adoption Agreement, the unused balance in a Participant's Health Reimbursement Account remaining at the end of a Plan Year may be carried over to the immediately following Plan Year.

(c) Change in status. If provided in the Adoption Agreement, a reduction in the number of Covered Persons may result in a forfeiture of prorated amounts from the Participant's Health Reimbursement Account. In addition, future contributions to the Participant's Health Reimbursement Account may be discontinued until the correct prorated amount is attained.

Section 4.03 CONTINUATION RIGHTS

(a) Leave of Absence/FMLA/USERRA. If the Plan is subject to FMLA or the Plan Administrator determines that the Plan is subject to FMLA, the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits as required by such applicable law. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by applicable law. The Plan Administrator shall permit Participants to continue to receive benefits as required under the Uniformed Services Employment and Reemployment Rights Act and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

(b) COBRA. If the Plan is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan is subject to COBRA, a Participant shall be entitled to continuation coverage with respect to his or her Health Reimbursement Account as prescribed in Code Section 4980B (and the regulations thereunder) or such applicable state statutes.

ARTICLE 5
NONDISCRIMINATION

Section 5.01 NONDISCRIMINATION

(a) The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code section 105(h)(5)) as to benefits provided or eligibility to participate with respect to the Health Reimbursement Account.

(b) Adjustment of Eligibility/Benefits. 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 eligibility requirement or benefit amount under the Plan in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Subsection shall be carried out in a uniform and non-discriminatory manner.

ARTICLE 6
REIMBURSEMENTS

Section 6.01 PROCEDURES FOR REIMBURSEMENT

(a) Benefits Provided by Insurance. All claims for benefits that are provided under insurance contracts shall be made by the Participant to the insurance company issuing such contract.

(b) Timing of Claims. Reimbursements and/or payments shall only be made for expenses incurred in the applicable Plan Year while the Participant participates in the Plan. Except as otherwise expressly provided herein, no reimbursement and/or payment shall be made for any expenses relating to services rendered before participation or after Termination of Employment for any reason. All claims for reimbursement and/or payment must be made within the time periods specified in the Adoption Agreement.

(c) Documentation. A Participant or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

(d) Payment. To the extent that the Plan Administrator approves the claim, the Company shall: (i) reimburse the Claimant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Health Reimbursement Account. The Plan Administrator shall establish a schedule, not less frequently than annually, for the payment of claims. The Plan Administrator may provide that payments/reimbursements of less than certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.

(e) Coordination with Cafeteria Plan. A Participant shall not be entitled to payment/reimbursement under a health care reimbursement account in a cafeteria plan sponsored by the Company to the extent the expense is reimbursable under this Plan. Notwithstanding the foregoing, the Adoption Agreement may provide that a Participant shall be entitled to payment/reimbursement under a health care reimbursement account in the cafeteria plan if before the cafeteria plan year begins, the Adoption Agreement specifies that coverage under this Plan is available only after the Participant has received his or her maximum reimbursement under a health care reimbursement account in the cafeteria plan.

(f) Death. If a Participant dies, his beneficiaries may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of the Participant's death. 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. If no beneficiary is specified, 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. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

(g) Form of Claim/Notice. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(h) Refunds/Indemnification. If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Company for any liability the Company 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 Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (ii) offset other benefits payable hereunder.

(i) Debit, Credit or Other Stored Value Cards. To the extent provided in the Adoption Agreement, the Company may enter into an agreement with a financial institution to provide a Participant with a debit, credit or other stored value card to provide immediate payment of reimbursements available under Section 4.01 provided that the use of such card complies with IRS Revenue Ruling 2003-43 (to the extent not superseded by IRS Notice 2006-69), IRS Notice 2006-69, IRS Notice 2007-2, IRS Notice 2008-104, IRS Notice 2010-59, IRS Notice 2011-5 and any superseding guidance. A Participant may obtain benefits under Section 4.01 without the use of the card.

(j) HSA Coordination. Except as otherwise provided in the Adoption Agreement, benefits under this Plan shall not be coordinated with coverage in a high deductible health plan to facilitate participation in Health Savings Accounts.

(k) Plan Administrator Procedures. The Plan Administrator may establish procedures regarding the documentation to be submitted in a claim for reimbursement and/or payment and may also establish any other procedures regarding claims for reimbursement and/or payment provided that the procedures do not violate ERISA section 503 if the Adoption Agreement indicates the plan is subject to ERISA. Such procedures may include, without limitation, requirements to submit claims periodically throughout the Plan Year.

Section 6.02 CLAIMS PROCEDURE

(a) A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) This Section 6.02(b) shall apply for any claim for benefits under the Health Reimbursement Account.

(1) 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 Plan 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.

(2) Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA, and (E): (I) 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 criterion will be provided free of charge to the Claimant upon request; or (II)

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.

(3) Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. 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, 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. The Plan 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 Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:

(A) 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 neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(B) 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;

(C) 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

(D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) 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 Plan 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.

(4) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) 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, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties.

(5) Exhaustion of Remedies. Before a suit can be filed in federal court, claims must exhaust internal remedies.

(c) Additional Internal and External Claims Procedures.

(1) Applicability. This Section shall apply if (A) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (B) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(2) Effective Date. This Section shall be effective the later of (A) the first plan year beginning after September 23, 2010 or (B) the date the Plan is no longer a grandfathered health plan under the Patient Protection and Affordable Care Act.

(3) Internal Claims Process. The claims requirements under the Plan shall apply as the internal claims process except as provided under DOL Reg. 2590.715-2719 and any superseding guidance.

(A) Adverse Benefit Determination. An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

(B) Full and Fair Review. A Claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

(C) Notice. A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(4) Deemed Exhaustion of Internal Claims Process. If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the claimant may initiate an external review under Section 6.02(c)(5) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

(5) Federal External Claims Process.

(A) State External Claims Process. If the Adoption Agreement specifies that the Plan is not subject to ERISA and the State external claims process includes at a minimum the consumer protections in the NAIC Uniform Model Act then the plan must comply with the applicable State claims review process.

(B) Federal External Claims Process. The plan must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance if Subsection (c)(5)(A) above is not applicable.

(d) Notwithstanding anything to the contrary, if the Adoption Agreement specifies that (1) the Plan is not subject to ERISA and (2) the Plan does not constitute a group health plan as defined in Treas. Reg. section 54.9801-2 or the Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Company and any other applicable law.

Section 6.03 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

Section 6.04 MISSING PAYEE

If the Plan Administrator 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 Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

ARTICLE 7
PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator shall be specified in the Adoption Agreement. In the absence of a designation in the Adoption Agreement, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA (if the Adoption Agreement provides that the Plan is subject to ERISA), and as such shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 6;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(viii) to determine all questions of the eligibility of Employees and of the status of rights of Participants;

(ix) to adjust Accounts in order to correct errors or omissions;

(x) to determine the validity of any judicial order;

(xi) to retain records on elections and waivers by Participants;

(xii) to supply such information to any person as may be required;

(xiii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

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

(f) 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 Company.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 7.02 INDEMNIFICATION

Unless otherwise provided in the Adoption Agreement, the Company shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA to the extent that the Adoption Agreement provides the Plan is subject to ERISA.

Section 7.03 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

If the plan is not subject to ERISA any applicable law related to qualified medical child support orders or National Medical Support Notices shall apply and the Plan Administrator shall follow any required procedures under such law.

Section 7.04 HIPAA PORTABILITY RULES

In the event the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan shall comply with the requirements of Code section 9801 et. Seq. including the requirement to cover children until the attainment of age 26 if the Plan makes dependent coverage of children available.

Section 7.05 THIRD PARTY RECOVERY/REIMBURSEMENT

(a) In General. When a Participant or covered dependent receives Plan benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Participant shall reimburse the Plan for the related Plan benefits received out of any funds or monies the Participant recovers from any third party.

(b) Specific Requirements and Plan Rights. Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Participant or covered dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to subrogation applies regardless of the manner in which the recovery is structured or worded, and even if the Participant or covered dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Participant to assert a claim to any of the benefits to which the Participant or a covered dependent may be entitled. The Plan will not pay attorneys fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Plan should become aware that a Participant or covered dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant or covered dependents.

(c) Participant Duties and Actions. By participating in the Plan each Participant and covered dependent consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Participant and covered dependent agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once a Participant or covered dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. And, at that time, the Participant (and the Participant's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

If a Participant fails or refuses to execute the required subrogation/ reimbursement agreement, the Plan may deny payment of any benefits to the Participant or covered dependent until the agreement is signed. Alternatively, if a Participant fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Participant or a covered dependent, the Participant's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

Each Participant and covered dependent consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

ARTICLE 8
AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor.

Section 8.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the Company reserves the right to terminate its participation in this Plan. Each such entity constituting the Company shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Company, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company.

ARTICLE 9
MISCELLANEOUS

Section 9.01 NONALIENATION OF BENEFITS

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

Section 9.02 NO RIGHT TO EMPLOYMENT

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

Section 9.03 NO FUNDING REQUIRED

Except as otherwise required by law:

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

(b) The Company 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. However, the Company 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 any rights to, or interest in, any Account other than as expressly authorized in the Plan.

Section 9.04 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 9.05 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 9.06 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 9.07 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 9.08 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

ARTICLE 10
HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article 10 shall only apply in the event that the Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy and security rules. The Plan will comply with HIPAA as set forth below.

Section 10.01 Definitions. For purposes of this Article 10, the following terms have the following meanings:

(a) "Business Associate" means any outside vendor who performs a function or activity on behalf 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 the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

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

(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 ("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 or the Plan Sponsor;

(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 10.02 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 and health insurance issuer, HMO, 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:

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

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

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

(D) 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 or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by 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, and will not permit a health insurance issuer or HMO to, 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 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, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO 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 and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(2) The Plan and any health insurance issuer or HMO 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.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

(f) Rights of Individuals.

(1) Notice of Privacy Practices. The Plan Sponsor will provide a Notice of Privacy Practices to the Participant in accordance with HIPAA.

(2) Right to Request Restrictions. Each Individual has the right to request that the Plan restrict its uses and disclosures of the Individual's PHI.

(3) Right to Access. Each Individual has the right to obtain and inspect its PHI held by the Plan.

(4) Right to Amend. Each Individual has the right to ask the Plan to amend its PHI.

(5) Right to an Accounting. Each Individual has the right to request an accounting of disclosures of PHI made by the Plan for purposes other than treatment, payment or health care operations.

Section 10.03 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.

TOWN OF SEABROOK

HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

January 1, 2017 Amended & Restated January 1, 2020

TOWN OF SEABROOK
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

INTRODUCTION

Town of Seabrook (the "Company") established the Town of Seabrook Health Reimbursement arrangement (the "Plan") effective 06/01/2012. This Summary Plan Description describes the Plan as amended and restated effective 01/01/2020.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

ELIGIBILITY FOR PARTICIPATION

Eligible Employee

You are an "Eligible Employee" if you are eligible to receive benefits from the Anthem BCBS NH Lumenos 2500 Plan.

You will stop being a participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date you terminate employment with the Company.

HEALTH REIMBURSEMENT BENEFITS

Health Reimbursement Account

When you become eligible to participate in the Plan, the Plan will establish a health reimbursement account in your name. You will be entitled to receive reimbursement from this account for Eligible Expenses incurred by you, your spouse and dependents - but only if such persons are covered under the Anthem BCBS NH Lumenos 2500 Plan (Covered Persons). A dependent is generally someone who you may claim as a dependent on your federal tax return and also includes a child up until their 26th birthday. You may receive reimbursement for Eligible Expenses incurred at a time when you are actively participating in the Plan. The amount of reimbursement for Eligible Expenses is limited to the annual limit described below.

Limits on Reimbursement

The annual limit on reimbursement is See Appendix A.

Deductible

The annual Plan deductible is $See Appendix A.

You must meet the annual deductible above before your Plan will reimburse for Eligible Expenses. Please note that the deductible above is for this plan (the Health Reimbursement Account) and NOT the deductible(s) for Company-sponsored health plan(s).

Eligible Expenses

During the time you are eligible to participate in the Plan, the Plan will reimburse all medical expenses for Covered Persons that are listed on the Eligible Expenses Appendix. The Plan will not reimburse you for the cost of medicines or drugs unless such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. You will not be reimbursed for any expenses that are (i) not incurred in the Plan Year, (ii) incurred before or after you are eligible to participate in the Plan, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source.

Coordination with Other Plans

All claims for benefits that are covered by an insurance policy must be made to the insurance company issuing such insurance policy.

Limits on Certain Employees

If you are a highly paid employee or an owner of the Company, federal law may impose limits on your eligibility to participate in the Plan and/or the benefits you may receive from the Plan.

CLAIMS

Deadlines

You must submit claims for reimbursement within 90 days after the end of the Plan Year. However, if you terminate employment you must submit claims for reimbursement within 90 days after your date of termination.

Debit/Credit Cards

The Company will provide you with a debit, credit or other stored-value card for purposes of making purchases that may be reimbursed from your health reimbursement account. The Plan Administrator will provide you with more information about stored value cards at the time you enroll in the Plan.

Documentation of Claims

Any claim for benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

Method and Timing of Payment

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Where to Submit Claims

All claims must be submitted to Benefit Strategies LLC at PO Box 1300, Manchester, NH 03105. The telephone number is 603-647-4666 and the Fax number is 603-647-4668.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for any liability the Company 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 you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Beneficiary

If you die, your beneficiaries may submit claims for Eligible Expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose provided that such beneficiary is your spouse or one or more of your dependents. If no beneficiary is specified, the Plan Administrator may pay any amount due to your spouse or, if there is no spouse, to your dependents in equal shares.

Claim Procedures for Health Benefits

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

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 Plan 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.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial, and (5): (A) 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 criterion will be provided free of charge to the Claimant upon request; or (B) 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.

Appeal of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. 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, 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. The Plan 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 Plan Administrator may deem relevant. In considering the appeal, the Plan 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 neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(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 Subsection (2) 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 Plan 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.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial with a discussion of the decision, (2) the pertinent Plan provisions on which the denial is based, (3) 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, and (4) a statement describing the external appeals process. The determination rendered by the Plan Administrator shall be binding upon all parties.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving benefits.

YOUR RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections. You have the right to:

Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including insurance contracts.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Certificates of creditable coverage are no longer required after December 31, 2014.)

In addition, the people who operate the Plan have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under the Plan.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done.

If you disagree with the Plan's decision or lack thereof concerning the status of a qualified medical child support order or national medical support notice, you may file suit in Federal and/or state court.

If you have any questions about the Plan, you should contact the Plan Administrator.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO) and/or National Medical Support Notice. You may obtain a copy of the medical child support procedures from the Plan Administrator, free of charge.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Newborns' And Mothers' Health Protection

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Loss of Benefit

You may lose all or part of your account if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is Town of Seabrook.

   Its address is P.O. Box 456, Seabrook, NH 03874.

   Its telephone number is 603-474-8025.

   Its Employer Identification Number is 02-6000833.

2. The Plan is a welfare benefit plan which has been designated by the sponsor as its plan number is 502.

3. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.

4. The Company's fiscal year and the plan year end on 12/31.

Eligible Expenses Appendix

Medical Deductible and RX Deductible are eligible expenses.HRA FireHRA will reimburse the first $2,150/$4,300Participant is responsible for last $350/$700HRA SSEAHRA will reimburse the first: $2,000/$4,500Participant is responsible for last: $500/$500HRA SSEA Post 4/1/19* (Participant must submit manual claims to meet deductible)Participant is responsible for first: $2,500/$2,500HRA will then reimburse the last: $0/$2,500HRA SEA Post 4/1/15* (Participant must submit manual claims to meet deductible)Participant is responsible for first: $1,850/$2,500HRA will then reimburse the last: $650/$2,500HRA 100%HRA will reimburse 100% $2,500/$5,000

COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your spouse dies;

Your spouse's hours of employment are reduced;

Your spouse's employment ends for any reason other than his or her gross misconduct;

Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

The parent-employee dies;

The parent-employee's hours of employment are reduced;

The parent-employee's employment ends for any reason other than his or her gross misconduct;

The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

The parents become divorced or legally separated; or

The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment; Death of the employee; The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Local Government Center at PO Box 617, Concord, NH 03301. The telephone number is 1-800-527-5001.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the

second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Local Government Center
PO Box 617, Concord, NH 03301
1-800-527-5001

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