General Board
Pension and Health Benefits

Caring For Those Who Serve

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HealthFlex Plan
(HealthFlex Plan Document)

A Program of Group Health Care Plans, Cafeteria and Flexible Spending Account Plans, Health Reimbursement Accounts, and Other Accident and Health Benefits for Conferences, Churches and Other Institutions Located in Jurisdictional Conferences of The United Methodist Church

Effective January 1, 2014

As Amended July 24, 2015

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Article 1 — General Purpose

1.01 History. This Plan is an amendment and restatement of the HealthFlex Program, formerly called the Hospitalization and Medical Expense Program, including added and revised provisions, effective January 1, 2014. The Plan was established as a welfare benefit program for clergy and lay employees of The United Methodist Church effective January 1, 1961. The Plan was amended and restated in 1994 and again in 2007.

1.02 The Plan. The Plan for any Plan Sponsor consists of the following subdivisions, plus any others that may be added to the Plan (and minus any subdivisions that may be removed from the Plan), at the discretion of the Plan Administrator, from time to time:

(a) the Group Health Plan;

(b) the Medical Reimbursement Account Program (MRA);

(c) the Dependent Care Account Program (DCA);

(d) the HealthFlex Benefit Booklet or certificate of insurance for any elected Group Benefit Options under the Group Health Plan;

(e) the Health Reimbursement Account (HRA, also called Health Reimbursement Arrangement);

(f) the Medicare Connector Program, if the Plan Sponsor has elected; and

(e) the Adoption Agreement for that Plan Sponsor.

The Plan may consist solely of the Medicare Connector Program and the Adoption Agreement for a Plan Sponsor that adopts the Medicare Connector Program and no other component of the Plan. The Plan will apply to a Participant, Disabled Participant, Retired Participant, Terminated Participant, or a covered Dependent as of the date such person first became eligible for the Plan. Claims for benefits incurred before this effective date must be submitted under the provisions of the Plan in effect on the date the claim was incurred.

1.03 Nature of Plan. The Plan is intended to be a program of one or more church-sponsored employee welfare benefit plans within the meaning of ERISA §3(1). Plan Sponsors may or may not be Affiliates of one another. For the purpose of Code §414(e), the Plan Sponsors are each intended to be a church, a convention or association of churches (within the meaning of Code §414(e)(3)(C)), or an organization controlled by or associated with a church or a convention or association of churches (within the meaning of Code §414(e)(3)(D)). Accordingly, the Plan Sponsors are intended to be one employer for the purpose of Code §414(e). Further, the Plan is intended to meet the requirements of a "church plan" as that term is defined in Code §414(e) and ERISA §3(33), and to be exempt from ERISA as a Church Plan to the extent permitted under Code §410(d) and ERISA §4(b)(2), and any other applicable law. As a Church Plan, the Plan is also intended to be exempt from COBRA continuation coverage requirements pursuant to Code §4980B(d) and Treasury Regulations §54.4980 B-2, Q. and A. No. 4. For the purpose of the Medicare Secondary Payer rules, the Plan is intended to be a multiple employer group health plan whose participating and electing small employers, for which the Plan has submitted and may continue to submit an election to

the Centers for Medicare and Medicaid Services, are exempt from the Medicare Secondary Payer rules under §1862 of the Social Security Act at 42 U.S.C. §1395y(b)(1)(A)(iii).

Moreover, generally, the Plan is intended to be administered as a "cafeteria plan" as that term is defined in Code §125(d). As a cafeteria plan, the Plan allows eligible Employees the opportunity to make contributions from their compensation to pay the cost of coverage under certain group benefit plans offered by the General Board of Pension and Health Benefits (General Board) and participating Plan Sponsors and established under separate written plans and agreements, and to receive eligible medical expense reimbursement and dependent care expense reimbursement on a before-tax basis, as permitted under Code §105 and §129. The Plan shall not provide for any deferred compensation of any nature; provide for any benefit that defers the receipt of compensation; or, operate in a manner that enables Participants to defer the receipt of compensation. The Plan is a multiple employer church health plan for the purposes of the fees related to the Patient-Centered Outcomes Research Institute (PCORI) established under Section 6301 of the PPACA, which added Section 4376 of the Code, and the fees related to the transitional reinsurance program (ACA Reinsurance) established under Section 1341 of the PPACA. As such, the Plan Administrator shall pay the PCORI fees and ACA Reinsurance fees applicable to Plan Participants and other covered lives, e.g., Dependents, in accordance with the PPACA and applicable regulations. The Plan Administrator shall act as "plan sponsor" with respect to the PCORI fees and ACA Reinsurance fees and remit payment of such fees to the Internal Revenue Service or Department of Health and Human Services on behalf of all participating Plan Sponsors and their covered employers (Salary-Paying Units). Notwithstanding the foregoing, the Plan Administrator shall not pay the PCORI fee related to any Participants of Plan Sponsors in the Medicare Connector Program; any such PCORI fees due related to Medicare Connector Program Participants shall be paid by the applicable Plan Sponsor. Because the Plan is a multiple employer health plan maintained by a Plan Administrator whose primary purpose is providing employee benefits, the PCORI fees shall be paid from the assets of the Plan.

1.04 Defined Terms. As used in this Plan, capitalized terms, including acronyms, have the meanings set forth in Article II. When not set forth in that Article, capitalized terms have the meanings set forth in predecessor plans or the meanings given to them in *The Book of Discipline*, or applicable laws or regulations.

1.05 Funding. Required Contributions to fund the benefits provided under the Plan are made by the Plan Sponsors and Participants as provided in the Plan.

(a) ***The Trust.*** To receive such Required Contributions, the General Board has established the Trust pursuant to the Trust Agreement. All benefits under the Plan will be provided exclusively by distributions from the Trust. The Trustee has the powers and duties specified in the Trust Agreement. The General Board has the authority to replace the Trustee of the Trust at any time, or to establish additional Trusts to fund benefits under the Plan.

(b) ***Insurance Contracts.*** Benefits under the Plan may also, at the General Board's discretion, be provided by the purchase of insurance contracts, and, in such event, the term Trust will also include the Plan's interest, if any, in such insurance contracts. Such insurance contracts may be entered into by the General Board or by the Trustee in accordance with the General Board's direction.

(c) ***Flexible Spending Account Contributions.*** Notwithstanding the foregoing, amounts that Participants elect to contribute to the Medical Reimbursement Account Program and Dependent Care Account Program and all amounts that Plan Sponsors contribute to Participant Accounts under the Flexible Spending Account Component of the Plan shall be considered part of the general assets of the General Board and, at all times, shall be subject to the claims of the General Board's creditors.

(d) ***Medicare Part D.*** From time to time the General Board may apply, on behalf of the Plan, through the Retiree Drug Subsidy ("RDS") program established by the Department of Health and Human Services and the Centers for Medicare and Medicaid Services under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law No. 108-173), for the RDS on behalf of the Plan Sponsors in the Plan who provide prescription drug coverage to Medicare-eligible Retired Participants.

1.06 Plan Sponsors.

(a) *Eligible Entities*. Subject to the limitations of Section 1.06(b) below, any of the following entities that is eligible to participate in an employee welfare benefit plan that is a Church Plan and satisfies the Plan's underwriting requirements is eligible to execute an Adoption Agreement to be a Plan Sponsor under the Plan:

(i) An entity that is:

(A) controlled by or associated with The United Methodist Church;

(B) a Code §501(c)(3) organization or a self-employed minister within the meaning of Code §414(e)(5)(A)(i)(I); and

(C) eligible to sponsor a Church Plan.

(ii) An entity that:

(A) is not any of the following:

(I) controlled by or associated with The United Methodist Church;

(II) a Code §501(c)(3) organization; or

(III) a self-employed minister within the meaning of Code §414(e)(5)(A)(i)(I);

(B) but that pays one or more Clergypersons who are Under Episcopal Appointment to such entity; and

(C) that sponsors the Plan with respect to any such Clergyperson who qualifies under Code §414(e)(3)(B)(i), even though The United Methodist Church is deemed to be such Clergyperson's employer under Code §414(e)(3)(C). Notwithstanding the foregoing, any such Clergyperson will be treated as a Clergy Employee of the Plan Sponsor for the purposes of this Plan.

(iii) An entity described in Code §414(e)(2), provided that the Plan Administrator determines that the number of Participants covered by such Plan Sponsors meets the limits of Code §414(e)(2).

No other entity may be a Plan Sponsor of the Plan.

(b) ***Covered Employees.*** Plan Sponsors who qualify under Section 1.06(a) above may execute an Adoption Agreement with respect to the following types or classes of Employees:

(i) Lay Employees;

(ii) Clergy Employees; and

(iii) Retired Employees.

Subject to rules adopted by the Plan Administrator and the coverage and nondiscrimination requirements of the Code and Treasury Regulations, a Plan Sponsor may execute more than one Adoption Agreement covering different classifications of Employees.

1.07 Adoption of the Plan. An eligible Plan Sponsor may adopt the Plan in accordance with Article XIII and the terms of an Adoption Agreement. A Plan Sponsor may discontinue sponsoring the Plan in accordance with Article XIII and the terms of its Adoption Agreement.

Article II — Definitions

Each word and phrase defined in this Article II shall have the following meaning whenever such word or phrase is capitalized and used herein, unless a different meaning is clearly required by the context of the Plan. The definition of any term herein in the singular may also include the plural.

2.01 Account. The individual account or accounts established by the Plan Administrator under Article IV in the name of each Participant for the purpose of accounting for Contributions allocated to and benefits paid for a Participant.

2.02 Active Conference Member. A Clergyperson who is not a Terminated or Retired Conference member.

2.03 Active Employee. A Clergy Employee or Lay Employee who is not a Disabled Employee, Retired Employee, or on a Leave of Absence and has not had a Termination of Employment. Notwithstanding the foregoing, a Retired Employee who continues to work for a Plan Sponsor or Salary-Paying Unit, i.e., has "current employment status" with the Plan Sponsor or Salary-Paying Unit as described in the Medicare Secondary Payer Rules, shall be treated as an Active Employee for purposes of this Plan.

2.04 Adoption Agreement. An agreement executed by each Plan Sponsor and accepted by the Plan Administrator that is a part of this Plan and is the means by which a Plan Sponsor adopts the Plan and specifies any optional provisions, such as optional categories of eligibility and Group Benefit Options, which are a part of any Plan as to that Plan Sponsor.

2.05 Affiliate. Any entity that is:

(a) a corporation that is a member of the same controlled group of corporations, as defined in Code §414(b), as a Plan Sponsor;

(b) a trade or business, whether or not incorporated, that is under common control with a Plan Sponsor within the meaning of Code §414(c);

(c) a member of the same affiliated service group, as defined in Code §414(m), as a Plan Sponsor; or

(d) otherwise required to be aggregated with a Plan Sponsor pursuant to Regulations issued under Code §414(o), but that is not itself a Plan Sponsor.

2.06 Age. The age at the last birthday.

2.07 Annual Election and Enrollment Period. With respect to a Plan Year, the month of November immediately preceding such Plan Year, or other period prescribed by the Plan Administrator.

2.08 Appoint or Appointment. Officially appointed by a Bishop to a ministry pursuant to ¶425-¶430 of *The Book of Discipline*.

2.09 Associate Member. A person elected to associate membership in an Annual Conference within the meaning of ¶321 or ¶322 of *The Book of Discipline*.

2.10 Benefit Option. A qualified benefit defined in §125(f) of the Code that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an HMO option, or a PPO option).

2.11 Bishop. A bishop of The United Methodist Church elected by a Jurisdictional Conference in accordance with ¶405 of *The Book of Discipline* and continuing to serve under Section III of Chapter Three of Part V of *The Book of Discipline.*

2.12 Conference. For the purpose of this Plan and the Programs thereunder, the term "Conference" shall include Annual Conferences, Provisional Conferences and Missionary Conferences which are described in *The Book of Discipline* and which are located in Jurisdictional Conferences.

2.13 *The Book of Discipline*. *The Book of Discipline of The United Methodist Church 2012*, the body of church law as established by General Conference, as amended and restated from time to time. Cited paragraphs or other subdivisions are deemed to refer to successor provisions when an amendment or restatement of *The Book of Discipline* causes a change in location or citation.

2.14 CDHP. A Benefit Option under the Plan that is a consumer-driven health plan, also called a high-deductible health plan or high-deductible health coverage. The CDHP is designed to drive Participant behavior toward informed medical decision-making, and carries higher deductible and out-of-pocket limits than the PPO Benefit Options under the Plan. The CDHP is generally accompanied by an HRA, so Participants have Plan-provided, and if applicable, Plan Sponsor-provided financial assistance toward satisfying those higher deductibles.

2.15 Change in Status. An occurrence of any of the events described in Section 5.07(b), as well as any other events included under subsequent changes to §125 of the Code or regulations issued thereunder, which the General Board, in its sole discretion and on a uniform and consistent basis, determines are permitted under the Treasury Regulations.

2.16 Church Plan. An employee benefit plan established and maintained for its employees by a church or by a convention or association of churches as established in §414(e) of the Code and §3(33) of ERISA. Church plans are exempt from the requirements of Title I of ERISA by §4(b)(2) of ERISA and from COBRA continuation requirements by §4980B(d) of the Code and §54.4980 B-2, Q. and A. No. 4 of the Treasury Regulations.

2.17 Claim. A Claim is notification in a form acceptable to the Plan Administrator, Claim Administrator, or Recordkeeper that a service has been rendered or furnished to a Participant and a request for payment or reimbursement of charges for the service has been made. The Claim must include full details of the service received; including a Participant's name, identification number, other demographic or identifying information, the name and address of the provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the charge and any other information that the Plan Administrator, Claim Administrator, or Recordkeeper may request.

2.18 Claim Administrator. A third-party administrator to whom the Plan Administrator has delegated administrative duties under the Plan. Claim Administrators are generally engaged through contracts or agreements to perform administrative functions for the Plan, including, but not limited to, processing Claims for benefits hereunder, providing access to a network of health care providers, paying Claims, hearing appeals and communicating with Participants. Some Claim Administrators may be engaged as Insurers of certain benefits provided under the Plan through the execution of contracts and the purchase of insurance policies by the Plan and the Plan Administrator. The Plan Administrator may also delegate certain fiduciary duties to a Claim Administrator through an agreement, contract or insurance policy.

2.19 Claimant. A person who makes a Claim for benefits under the Plan or who appeals the denial of such a Claim, or such person's representative.

2.20 Clergy Employee. An Employee who is:

(a) a Clergyperson who is an Active Conference Member and Under Episcopal Appointment to, or on a Leave of Absence from, a Plan Sponsor; or

(b) a Bishop.

2.21 Clergyperson. One of the following persons who is not a Bishop:

(a) an Elder in Full Connection;

(b) a Deacon in Full Connection;

(c) a Local Pastor;

(d) a Provisional Member;

(e) an Associate Member; or

(f) a clergyperson of another denomination within the meaning of ¶346.1 or ¶346.2 of *The Book of Discipline*.

2.22 Code. The Internal Revenue Code of 1986, as amended from time to time, and any regulation, ruling, or other administrative guidance issued pursuant thereto by the Internal Revenue Service.

2.23 Collective Bargaining Agreement. An agreement between a Plan Sponsor or a Salary-Paying Unit and Employee representatives within the meaning of Code §7701(a)(46) under which benefits were the subject of good faith bargaining between the parties.

2.24 Compensation. The sum of the following:

(a) the cash salary received by the Participant from the Salary-Paying Unit and Plan Sponsor;

(b) the housing allowance, if any, determined in accordance with the provisions of the Clergy Retirement Security Program Section A2.30, as amended, or the United Methodist Personal Investment Plan Section 2.41, as amended;

(c) any salary-reduction contribution to a pension program administered by the General Board; and

(d) any Employee Contributions under Section 4.05(a) herein, on a Participant's behalf.

2.25 Conference. Any Annual Conference, Provisional Conference, or Missionary Conference that is described in *The Book of Discipline* and is located in a Jurisdictional Conference.

2.26 Contribution. A Plan Sponsor Contribution or a Participant Contribution.

2.27 Deacon in Full Connection. A member of the Order of Deacons within the meaning of ¶328-¶331 of *The Book of Discipline* who is a member of a Conference and not a Provisional Member.

2.28 Denominational Average Compensation. The average annual compensation as determined in accordance with Section A2.46 of the Clergy Retirement Security Program.

2.29 Dependent. For purposes of coverage under a Group Benefit Option, Dependent shall have the meaning defined in such Group Benefit Option. Dependent also may include, for Plan Sponsors who so elect through an Adoption Agreement, a same sex partner joined in a civil union or a domestic partnership, which, under the law of the state in which the Employee resides, provides the same substantive and procedural rights, privileges, and immunities as marriage. For the purposes of the Dependent Care Program, the term Dependent shall have the meaning described in Section 8.02.

2.30 Dependent Care Account Program. A dependent care reimbursement program, i.e., a dependent care flexible spending account arrangement, established by the Plan Administrator in accordance with Article VIII.

2.31 Disabled. Any of the following with respect to an Employee:

(a) determined to be disabled by the Social Security Administration;

(b) being disabled under the terms of the Comprehensive Protection Plan, as amended from time to time, or a successor plan;

(c) being disabled under the terms of the Basic Protection Plan, as amended from time to time, or UMLifeOptions or a successor plan; or

(d) being determined to be disabled by the Plan Administrator or its agents on the basis of objective medical evidence that the Employee is unable to perform the usual and

customary duties of his or her employment by reason of bodily injury, disease, or mental or emotional disease or disorder which will presumably last for at least six months, exclusive of any disability resulting from: (1) service in the armed forces of any country, (2) warfare, (3) intentionally self-inflicted injury, or (4) participation in any criminal or unlawful act.

After having been covered as a Disabled Participant for 24 months, the Participant shall continue to be considered Disabled only if such Participant is unable to engage in any occupation for which such Participant is reasonably qualified by training, education, experience, or age. In order to continue coverage after 24 months as a Disabled Participant, the Participant will be required to submit medical evidence of such ongoing disability to the Plan Administrator.

2.32 Early Retirement Age. The age or service completion date specified in ¶358.2*b* of *The Book of Discipline*; or, for a person who retires in accordance with ¶358.2*a* or ¶358.3 of *The Book of Discipline* or who is a Terminated Participant, age 55.

2.33 Early Retirement Date. The first day of the month coinciding with or next following the date an Employee Retires:

(a) in the case of a Clergy Employee, on or after:

(i) the age or service completion date specified in ¶358.2*b* of *The Book of Discipline*; or

(ii) age 55, in the case of a Clergy Employee who Retires in accordance with ¶358.2*a* (20 years of service) or ¶358.3 (involuntary retirement) of *The Book of Discipline*; or

(b) in the case of a Lay Employee who is employed by:

(i) a General Agency on or after:

(A) the date specified in the General Agency's policy on elective retirement for pension purposes (which must be consistent with ¶715.3 of *The Book of Discipline*); or

(ii) any Plan Sponsor other than a General Agency, in accordance with the Plan Sponsor's retirement policy.

2.34 Elder in Full Connection. A member of the Order of Elders within the meaning of ¶332-¶336 of *The Book of Discipline* who is a member of a Conference and not a Provisional Member.

2.35 Employee. A person who is described as an employee of a church in §414(e)(3) or §7701(a)(20) of the Code, who is a Bishop of The United Methodist Church, who is a Clergyperson serving The United Methodist Church, or who is a common-law employee of a Salary-Paying Unit.

2.36 Employee Contributions. The contributions made by an Employee pursuant to Section 4.05.

2.37 Employer Group Health Plan. An employer-sponsored self-insured group health plan or insured group health or HMO plan.

2.38 ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time, and any regulation, ruling, or other administrative guidance issued pursuant thereto by the Internal Revenue Service or the Department of Labor.

2.39 Five-Year No Record of Appointment. With respect to a Probationary Member, Associate Member, Deacon in Full Connection, or Local Pastor, a 60-consecutive-month period during which the Probationary Member, Associate Member, Deacon in Full Connection, or Local Pastor (or some combination in the case of a Clergyperson who changes classification) is not Under Episcopal Appointment.

2.40 Flexible Spending Account Component. The portion of the Plan that provides Participants the ability to defer Compensation to flexible spending accounts for health care expenses under §105 of the Code, and dependent care expenses under §129 of the Code.

2.41 FMLA. The Family and Medical Leave Act of 1993, as amended from time to time.

2.42 Form. Any means of recording and conveying an authenticated election or other authenticated information to the Plan Administrator, Claim Administrator, Salary-Paying Unit, or Plan Sponsor, including, but not limited to, the following:

(a) A signed paper form;

(b) A form submitted by internet or extranet, that is authenticated in a manner acceptable to the Plan Administrator, Claim Administrator, Salary-Paying Unit or Plan Sponsor to which the form is directed;

(c) An interactive voice response selection that is authenticated in a manner acceptable to the Plan Administrator, Claim Administrator, Salary-Paying Unit, or Plan Sponsor to which the selection is directed; and

(d) A recorded oral election or statement of information that is authenticated in a manner acceptable to the Plan Administrator, Claim Administrator, Salary-Paying Unit or Plan Sponsor to which the election or statement of information is directed.

2.43 General Agency. A general agency of The United Methodist Church as defined in ¶701 of *The Book of Discipline*.

2.44 General Board. The General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois.

2.45 General Conference. The General Conference of The United Methodist Church, the highest legislative body in the denomination, as described in Section I of Chapter Four of Part V of *The Book of Discipline*.

2.46 Group Benefit Option. A Plan Sponsor's arrangements to provide medical, dental, vision and other Benefit Options to Employees and their dependents and beneficiaries, as listed in

Exhibit A to its Adoption Agreement, as amended from time to time. A list of Group Benefit Options available under the Plan as of the effective date of this restatement is attached hereto as Appendix A. Under the Plan, generally, the Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Out of Area (OOA), Consumer-Driven Health Plan (CDHP), Medicare HMO, and Medicare companion plans for medical benefits with their corresponding prescription drug plans are considered separate Group Benefit Options, as are the mental and behavioral health HMO and PPO plans, the indemnity, PPO and HMO dental plans, and the exam core and full-service vision plans. The Plan Administrator, in its sole discretion, may add or delete Group Benefit Options at any time. Moreover, the Plan Administrator may also modify the terms of any Group Benefit Option to comply with applicable law and regulations, including, but not limited to the PPACA, PHSA and the Code.

2.47 Group Health Plan Component. The portion of the Plan that provides hospitalization, accident, prescription drug and other medical benefits.

2.48 HCERA. The Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), which amended certain provisions of the PPACA, and together with the PPACA is referred to as the PPACA, the Affordable Care Act or the Health Care Reform Act.

2.49 HIPAA. The Health Insurance Portability and Accountability Act of 1996.

2.50 HIPAA Regulations. The regulations promulgated pursuant to the authority granted under HIPAA by the Secretary of the Department of Health and Human Services.

2. 51 HRA. A Health Reimbursement Account, described in Article IX, which is health reimbursement arrangement as described in *IRS Notice 2002-45*. HRAs are employer-funded (i.e., Plan-funded and, if applicable, Plan Sponsor-funded) accounts that help Participants covered in the CDHP Benefit Option or another HRA-eligible Benefit Option as determined before the beginning of each Plan Year by the Administrator and by the election of the Plan Sponsor, satisfy higher deductibles and other out-of-pocket expenses by reimbursing certain eligible medical expenses. HRAs also help Retired HRA Participants pay for out-of-pocket health care expenses in retirement. HRAs do not include any Participant contributions. HRAs do not include the Medicare Connector HRAs as described in Article X.

2.52 Insurer. A third party that pays for benefits under the Plan through an insurance policy or agreement with the Plan Administrator, under which the third party has agreed to insure the Plan for the cost of such benefits and administer claims for such benefits in exchange for a premium paid by the Plan.

2.53 Jurisdictional Conference. One of the organizational units of The United Methodist Church, as described in Section II of Chapter Four of Part V of *The Book of Discipline*.

2.54 Lay Employee. Any Employee who is not a Clergy Employee. An Employee who is a Clergyperson but who is not:

(a) an Active Conference Member; or

(b) Under Episcopal Appointment to a Plan Sponsor

is a Lay Employee for the purposes of this Plan. This definition will not affect the fact that the Code treats certain Clergypersons (generally certain Deacons in Full Connection) as lay employees. Such Clergypersons and all Lay Employees may not be eligible for this Plan under Section 3.02(d) and §414(e) of the Code if they are employed by an entity that is not controlled by or associated with The United Methodist Church.

2.55 Leave of Absence. An Employee's period of absence from performing his or her duties for a Plan Sponsor:

(a) in accordance with ¶352 of *The Book of Discipline* or any Plan Sponsor leave policy relating to sabbatical leaves;

(b) in accordance with ¶354 and ¶355 of *The Book of Discipline* or any Plan Sponsor leave policy relating to leaves of absence;

(c) in accordance with ¶356 of *The Book of Discipline* or any Plan Sponsor leave policy relating to maternity or paternity leaves;

(d) because of a Medical Leave (under ¶357 of *The Book of Discipline*) or any Plan Sponsor leave policy relating to illness, injury, disability, medical or incapacity leaves (but not including any such leave for which salary continuance is offered);

(e) that is covered by USERRA (or applicable prior law); or

(f) to which the Employee is entitled under the Family and Medical Leave Act of 1993 or any comparable applicable state law;

provided, however, that the Employee Retires or returns to at least one hour of paid service for the Plan Sponsor or its Affiliate within the time specified when his or her leave is approved, including any later adjustments thereto (or, if applicable, within the period during which his or her re-employment rights are protected by law).

2.56 Local Pastor. A person licensed in accordance with Section IV of Chapter Two of Part V of *The Book of Discipline* (¶315-¶320).

2.57 Medical Leave. (Formerly called Incapacity Leave) a Conference relationship specified in ¶357 of *The Book of Discipline* applicable to Clergypersons. A Clergyperson must be placed on Medical Leave by his or her Conference, and not by a Plan Sponsor that is not a Conference. In the case of Bishops, Medical Leave, called Incapacity Leave for Bishops, is granted in accordance with ¶410.4 of *The Book of Discipline*. Individuals appointed to Medical Leave are not necessarily considered Disabled for the purposes of the Plan.

2.58 Medical Reimbursement Account Program. A medical reimbursement account program, i.e., a health care flexible spending account arrangement, established by the Plan Administrator in accordance with Article VII.

2.59 Missionary Conference. A special purpose conference of The United Methodist Church similar to an Annual Conference, as further described in Section VII of Chapter Four of Part V of *The Book of Discipline*.

2.60 Normal Retirement Date. The first day of the month coinciding with or next following the earlier of:

(a) the Employee's 65th birthday; or

(b) the date on which the Participant who is:

(i) a Clergyperson attains 40 years of service under ¶358.2*c* of *The Book of Discipline*;

(ii) a Lay Employee of a General Agency satisfies the requirements for normal or full retirement under the General Agency's policy on retirement of Employees; or

(iii) a Lay Employee of a Plan Sponsor other than a General Agency qualifies under any normal retirement policy the Plan Sponsor may have that applies to this Plan.

2.61 Notice. Any means of officially conveying Plan-related information to an Employee, a Participant, a Dependent, the Plan Administrator, Claim Administrator, a Salary-Paying Unit, a Plan Sponsor, or any other entity related to the Plan, including, but not limited to, the following:

(a) A paper communication;

(b) An internet or extranet communication;

(c) An e-mail or other electronic communication;

(d) An interactive voice response recorded statement; and

(e) An oral communication that is recorded and, when reasonably required, otherwise verifiable as to the originator of the communication;

provided, however, that any such communication complies with any applicable laws, Treasury Regulations or HIPAA Regulations, or other governmental rules. When proof that a communication has been delivered is needed, the method of communication must be reasonably evidenced, including having issued such communication in the normal course of business. When a communication would reasonably be acceptable only if signed, notarized, or otherwise authenticated, it must be signed, notarized, or otherwise authenticated. An unrecorded oral communication will not qualify as a Notice unless the Plan Administrator has established a rule allowing such an oral communication to qualify as a Notice.

2.62 Open Enrollment Period. The Open Enrollment Period is the period of time during which eligible Employees may enroll themselves and their Dependents in the Plan. The Plan Administrator will determine the period of time that is the Open Enrollment Period. Generally, the Open Enrollment Period lasts 30 days from the date the Employee first becomes eligible under Article III.

2.63 Other Group Health Plan. Coverage or insurance including a self-insured group health plan; an individual or group health insurance or HMO plan; Parts A and B of Medicare; Medicaid; a health plan for current and former members of the armed forces; a health plan provided through Indian Health Services; a state health benefit risk pool; The Federal Employees Health Program; a plan provided under the Peace Corps Act; a state, county, or municipal public health plan; a State Children's Health Insurance Program (S-CHIP); health coverage provided under a plan established by a foreign country; coverage provided under state or federal health continuation mandates (e.g., COBRA); individual or group health insurance through an association; or an individual or group health conversion plan.

2.64 Other Health Coverage. Coverage under an Other Group Health Plan, any individual health insurance, or public health plan.

2.65 Participant. Any Employee who has become eligible to participate in the Plan in accordance with Section 3.01, who has enrolled in the Plan.

(a) ***Active Participant.*** Any Participant who is not a Disabled Participant, Retired Participant or Terminated Participant.

(b) ***Disabled Participant.*** Any Participant who is Disabled as defined in Section 2.31.

(c) ***Retired Participant.*** Any Participant who is described in Sections 3.03(a), (b)(viii), (b)(ix), (b)(x), (d), (e)(ii), or (f), below, who has satisfied the requirements of Section 3.05(g).

(d) ***Terminated Participant.*** A person described in Section 2.90.

2.66 Pastoral Charge. One or more Local Churches within the meaning of ¶205 of *The Book of Discipline*.

2.67 Period of Coverage. The Plan Year, with the following exceptions:

(a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences as provided in Section 5.04; and

(b) for Employees who terminate participation, it shall mean the portion of the Plan Year up to the date participation terminates as provided in Section 5.04.

2.68 PHSA. The Public Health Service Act (Public Law 78-410) as amended by the PPACA and HCERA.

2.69 Plan. HealthFlex or HealthFlex Program, formerly known as the Hospitalization and Medical Expense Program, a group health care and flexible spending account plan of The United Methodist Church, as further described in Section 1.03, as amended.

2.70 Plan Administrator. The General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois, or any successor.

2.71 Plan Sponsor. An entity specified in Section 1.07 that has executed an Adoption Agreement with respect to those of its Employees who are:

(a) permitted to be covered under Section 1.06(b); and

(b) specified by type or class of Employee in the Adoption Agreement.

2.72 Plan Sponsor Contributions. The contributions made by a Salary-Paying Unit or a Plan Sponsor pursuant to Section 4.05.

2.73 Plan Year. The 12-month period ending on December 31 of each calendar year.

2.74 PPACA. The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), also known as the Health Care Reform Act, the Affordable Care Act, and the ACA, which substantially amended the Code, ERISA and the PHSA, and which affects the Plan through various insurance market and group health plan reforms.

2.75 Preferred Risk Pool. The risk pool for Plan Sponsors designed to maximize the distribution of the risk of large claims. The Preferred Risk Pool requires that the Plan Sponsor pay: (i) Required Contributions for all eligible Clergy Employees who are enrolled in the Plan, subject to exceptions that the General Board may establish and amend from time to time; and (ii) a surcharge for risk equal to the Required Contribution for coverage of an Employee for each Clergy Employee who has declined coverage in the Plan. Clergy Employees for this purpose include both "basic coverage" and "additional coverage" categories selected on the Plan Sponsor's Adoption Agreement, where indicated in the Adoption Agreement that the Risk Pool Rules apply. The mandatory payment of surcharges for risk does not imply that "participation" or "coverage" of eligible individuals is mandatory, but rather all churches and Salary-Paying Units with appointed eligible Clergy Employees share in the cost and the risk of providing a group health plan for all Clergy Employees as part of the connectional philosophy of The United Methodist Church.

2.76 Privacy Rule. The Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations (CFR) parts 160 and 164, subparts A and E.

2.77 [Reserved].

2.78 Protected Health Information. Protected Health Information or "PHI" shall have the same meaning as the term "protected health information" at 45 CFR §160.103, limited to the information created or received by the General Board and Plan.

2.79 Provisional Member. A person elected to provisional membership in an Annual Conference within the meaning of ¶324 of *The Book of Discipline*.

2.80 Recordkeeper. The General Board or a third-party administrator or custodian appointed by the General Board pursuant to Section 7.09 or Section 8.13.

2.81 Required Contribution. Required Contributions include, but are not limited to, amounts due under Section 4.05, premiums for coverage under the Plan, and any other amounts due as a condition of receiving coverage under the Plan.

2.82 Retire or Retirement. In the case of:

(a) a Clergy Employee, either:

(i) being placed in the retired relation in accordance with ¶358 of *The Book of Discipline*; or

(ii) incurring, on or after his or her Early Retirement Date a Termination of Employment and either:

(A) a Termination of Conference Relationship; or

(B) a Five-Year No Record of Appointment;

(b) a Lay Employee, the earliest of:

(i) the date such Lay Employee incurs a Termination of Employment on or after his or her Early Retirement Date;

(ii) in the case of a Disabled Lay Employee, his or her Early Retirement Date or Normal Retirement Date; or

(iii) in the case of a Lay Employee on an approved Leave of Absence who does not return to work at the scheduled end of a Leave of Absence, the date the Leave was scheduled to end if such date is on or after his or her Early Retirement Date; or

(c) a Terminated Participant, his or her Early Retirement Date or Normal Retirement Date, if his or her Plan Sponsor allows the option to become a Retired Participant to be tolled in certain circumstances during the period of time between the Termination of Employment and the Early Retirement Date or Normal Retirement Date.

2.83 Retired Employee. A Clergy Employee or Lay Employee who has Retired.

2.84 Retirement Date. The date on which a Participant satisfies the requirements of Section 2.62(c).

2.85 Risk Pool Rules. The General Board may establish and enforce eligibility, participation and coverage rules for mitigating adverse selection risk and moral hazard, spreading the risk of large claims among Plan Sponsors and reflecting the connectional nature of the denomination. General Board staff may establish and amend, from time to time, a Preferred Risk Pool for Plan Sponsors and a Standard Risk Pool for Plan Sponsors, among other mechanisms for managing risk, and may amend the rules from time to time. The Risk Pool Rules may vary between Conference Plan Sponsors and other Plan Sponsors; among Conference Plan Sponsors; and between Clergy Employees and Lay Employees.

2.86 Salary-Paying Unit. One of the following units associated with The United Methodist Church and located in the United States of America:

(a) the General Conference;

(b) a General Agency of The United Methodist Church;

(c) a Jurisdictional Conference;

(d) a Conference located in a Jurisdictional Conference;

(e) a Conference board, agency, or commission located in a Jurisdictional Conference;

(f) a local church located in a Conference; or

(g) any other organization located in a Jurisdictional Conference which is eligible to participate in a Church Plan in accordance with the provisions of ERISA and the Code.

2.87 Security Rule. The standards for the security of electronic protected health information at 45 CFR 164, Subpart C.

2.88 Spouse. The husband or wife or surviving husband or wife of a Participant who is legally married to such Participant, or was so legally married on the date of the Participant's death, under the laws of the jurisdiction where the Participant resides or resided. Notwithstanding the foregoing, the term "Spouse" will not include common law spouses, even in states that recognize common law marriage.

2.89 Standard Risk Pool. The risk pool or risk pools, established, maintained and terminated from time to time by the Administrator, for Plan Sponsors who do not choose to participate in the Preferred Risk Pool.

2.90 Terminated Participant. A person who has been a Participant under the Plan as sponsored by a Plan Sponsor, but who:

(a) is a Lay Employee and has incurred a Termination of Employment with such Plan Sponsor or elects to terminate participation during an Annual Election and Enrollment Period or on account of a Change in Status;

(b) is a Clergy Employee and has incurred a Termination of Conference Relationship, or elects to terminate participation during an Annual Election and Enrollment Period or on account of a Change in Status;

(c) is a Dependent of an Employee and: (i) ceases to be a Dependent as defined in Section 2.29, or (ii) ceases to be covered under the Plan by the election of the Participant during an Annual Election and Enrollment Period or on account of a Change in Status;

(d) is a Retired Participant who has elected to terminate participation in the Plan at any time;

(e) is a Disabled Participant and ceases to be Disabled as defined in Section 2.31;

(f) is excluded from participation pursuant to Section 3.06(f) or by operation of any other Plan rule or provision;

(g) is enrolled in the Plan at the time his or her Plan Sponsor terminates its sponsorship of the Plan; or

(h) is enrolled in the Plan at the time the Plan is terminated by the General Board.

Notwithstanding the foregoing, a Terminated Participant may elect to continue coverage under the Plan pursuant to Section 3.06(e) only as long as permitted by the Plan and the applicable Adoption Agreement.

2.91 Termination of Conference Relationship. A Participant ceasing to be a member of any Conference, including by reason of:

(a) being honorably located within the meaning of ¶359 of *The Book of Discipline*;

(b) his or her withdrawal within the meaning of ¶361 of *The Book of Discipline*;

(c) the surrender of his or her ministerial credentials within the meaning of ¶361.2 and ¶2719.2 of *The Book of Discipline*; or

(d) the surrender of his or her Local Pastor's license within the meaning of ¶320.1 of *The Book of Discipline*.

2.92 Termination of Employment.

(a) ***General Rule.*** A non-conference responsible Clergy Employee or a Lay Employee will be deemed to have incurred a Termination of Employment with a Plan Sponsor as a result of his or her:

(i) resignation or dismissal for any reason (whether or not it qualifies as a Retirement);

(ii) the end of a Clergy Employee's Appointment to such Plan Sponsor that results in the Employee's severance from employment with such Plan Sponsor as both a Clergy Employee and as a Lay Employee;

(iii) death;

(iv) failure to return to work promptly upon the request of such Plan Sponsor at the end of a layoff;

(v) failure to return to work within the period required under USERRA or any other law pertaining to veterans' re-employment rights after having started an authorized Leave of Absence for military duty with the armed forces of the United States as defined under such law;

(vi) failure to Retire or return to work at the end of a Leave of Absence; or

(vii) transfer from such Plan Sponsor to another Plan Sponsor;

provided that such Retirement, resignation, dismissal, end of Appointment, death, failure to return, failure to Retire, or transfer involves a severance from employment with such Plan Sponsor.

(b) ***Failure to Return after Layoff or Leave.*** If a Termination of Employment occurs within the meaning of Sections 2.92(a)(iv)-(vi), such termination will be deemed to have occurred on the first day of the layoff or Leave of Absence. An Employee who timely returns to work with such Plan Sponsor at the end of the layoff or Leave of Absence will not have incurred a Termination of Employment with such Plan Sponsor by reason of such layoff or Leave of Absence.

2.93 Treasury Regulation. Any applicable regulation, including proposed and temporary regulations, issued by the Department of the Treasury or Internal Revenue Service that is codified at Title 26 of the Code of Federal Regulations. Where a reference is made to temporary or proposed regulations, such reference will include any permanent regulations, modified proposed regulations, or temporary regulations issued in lieu thereof.

2.94 Trust. The trust or trusts, including the Employee Health Benefit Trust of The United Methodist Church, established to fund certain benefits provided under the Plan, as provided in Section 1.05(a). The term "Trust" will also include, as applicable, any insurance contract purchased to fund benefits under the Plan.

2.95 Trust Agreement. The agreement or agreements between the Administrator and the Trustee pursuant to which the Trust is established.

2.96 Trustee. The UMC Benefit Board, Inc. or any successor.

2.97 Under Episcopal Appointment. The condition of a Clergyperson who has been appointed by a Bishop to a ministry pursuant to ¶425 through ¶430, Section VIII of Chapter Three of *The Book of Discipline*.

2.98 USERRA. The Uniformed Services Employment and Re-employment Rights Act of 1994.

Article III — Eligibility

3.01 General Rule. An Employee shall be eligible to participate in this Plan if the Employee meets the requirements of Sections 3.02, 3.03, or 3.06 below and the enrollment requirements of Section 3.05, and if he or she is not excluded from participation in accordance with the provisions of Sections 3.04 or 3.06 below.

3.02 Basic Participation. An Employee who is one of the following shall be eligible to participate in this Plan:

(a) an active Bishop of The United Methodist Church;

(b) a Clergy Employee of a Conference, including full, probationary, and associate, who is Appointed:

(i) to full-time service in a Local Church in accordance with ¶337.1 or ¶346.1 of *The Book of Discipline*; or

(ii) to an Appointment extending the ministry of the local United Methodist church within the connectional structure to a unit of the Conference in accordance with ¶344.1 of *The Book of Discipline*;

(c) a full-time Local Pastor determined in accordance with ¶318.1 of *The Book of Discipline* who is Under Episcopal Appointment to a Pastoral Charge that is located in a Conference;

(d) a Lay Employee of a General Agency who is normally scheduled to work 30 or more hours per week, excluding, however, a person who is employed by a General Agency as a missionary of The United Methodist Church;

(e) a Clergy Employee of a General Agency;

(e) a Lay Employee of a Plan Sponsor other than a Conference or General Agency who is normally scheduled to work 30 hours or more per week.

3.03 Additional Participation. An Employee in one of the following categories shall be eligible to participate in this Plan if his or her Plan Sponsor elects, pursuant to an Adoption Agreement, to enroll the category of Employee, set forth below, in which he or she falls.

(a) a Bishop who has Retired in accordance with ¶408.1, ¶408.2 or ¶408.3 of *The Book of Discipline*;

(b) a Clergy Employee of a Conference who:

(i) is Appointed to less than full-time service in accordance with ¶338.2 of *The Book of Discipline*, but who is Appointed to at least half-time time service;

(ii) is Appointed beyond the local United Methodist Church within the connectional structure to an entity other than a unit of a Conference or other than a General

Agency in accordance with ¶344.1a of *The Book of Discipline*, including full-time Local Pastors so Appointed in accordance with ¶316 of *The Book of Discipline*;

(iii) is Appointed beyond the local United Methodist Church to an extension ministry endorsed by the General Board of Higher Education and Ministry in accordance with ¶344.1b of *The Book of Discipline*;

(iv) is Appointed beyond the local United Methodist Church outside the connectional structure in accordance with ¶344.1d of *The Book of Discipline*;

(v) is granted a Leave of Absence as defined in Section 2.55 of the Plan;

(vi) is Appointed to attend school in accordance with ¶416.6 of *The Book of Discipline*;

(vii) has Retired in accordance with ¶358.1, ¶358.2b or ¶358.2c of *The Book of Discipline*;

(viii) has Retired in accordance with ¶358.2a of *The Book of Discipline*; or

(ix) has Retired in accordance with ¶358.3 of *The Book of Discipline*.

(c) a Local Pastor of The United Methodist Church who is Under Episcopal Appointment and who is:

(i) a "part-time local pastor" as that term is defined in ¶318.2 of *The Book of Discipline*, who is Appointed to at least a three-quarter time appointment; or

(ii) a "student local pastor" as that term is defined in ¶318.3 of *The Book of Discipline*.

(d) a full-time Local Pastor who was eligible to participate in the Plan and who has been recognized as a Retired Local Pastor in accordance with ¶320.5 of *The Book of Discipline*;

(e) a Lay Employee of a Conference or Salary-Paying Unit within a Conference who:

(i) is normally scheduled to work 30 hours or more per week; or

(ii) has Retired at Early Retirement Age or Normal Retirement Age in accordance with the retirement policy of the Salary-Paying Unit from which he or she has Retired.

(f) a Lay Employee of a General Agency or other Plan Sponsor who has Retired in accordance with the retirement policy of the General Agency or Plan Sponsor from which he or she has Retired.

3.04 Exclusions.

(a) A Clergyperson shall be excluded from participation in the Plan when:

(i) he or she is granted "honorable location" as that term is defined in ¶359.1 of *The Book of Discipline*;

(ii) he or she is granted a status as defined in ¶361 of *The Book of Discipline*.

(b) A Lay Employee shall be excluded from participation in the Plan when:

(i) he or she normally is scheduled by the Plan Sponsor or Salary-Paying Unit to work fewer than 30 hours per week.

3.05 Enrollment Requirements.

(a) The General Board may establish enrollment and coverage requirements that a Plan Sponsor must satisfy in order to qualify for the Preferred Risk Pool, and the General Board may amend such requirements from time to time.

(b) The General Board may establish enrollment and coverage requirements that a Plan Sponsor must satisfy in order to qualify for the Standard Risk Pool, and the General Board may amend such requirements from time to time.

(c) The General Board may establish minimum enrollment requirements that a Plan Sponsor must satisfy in order to participate in this Plan.

(d) The Plan Sponsor must make the Plan available to all of its eligible Employees in the Basic Participation Group in Section 3.02, if any, and to all of its eligible Employees in the categories that it selected for the Additional Participation Group in Section 3.03 on a nondiscriminatory basis in accordance with the applicable nondiscrimination rules of the Code and the PPACA, but may exclude Lay Employees who are normally scheduled to work fewer than 30 hours per week and other Employees defined in Section 3.04(b).

(e) In order to participate in this Plan, an Employee must enroll in the Plan within 30 days of becoming eligible to participate in the Plan. The Employee's Plan Sponsor has the duty to timely submit enrollment materials and Forms from Employees to the Plan Administrator.

(f) An Employee shall be denied enrollment in the Plan if he or she does not meet the conditions of Section 3.05(e) in accordance with rules and regulations established by the Plan Administrator.

(g) ***Retired Participants.*** An eligible Employee described in Sections 3.03(b)(viii), (b)(ix), (b)(x), (e)(ii), or (f) shall be eligible to participate in the Plan, subject to the terms of the Adoption Agreement of his or her Plan Sponsor, and the retirement eligibility rules of his or her Plan Sponsor, as a Retired Participant. In addition, a Spouse who is married to an Employee in one of the categories described in this Section is eligible to become a

Retired Participant as described in this Section subject to the Adoption Agreement and eligibility rules of the Plan Sponsor, although he or she will immediately lose such eligibility if the Employee or Retired Participant to whom he or she is married loses his or her eligibility unless such loss of eligibility is on account of the Employee's death.

(i) *Years of Coverage and Plan Sponsor Requirements.* Notwithstanding anything else in the Plan to the contrary, to become a Retired Participant in the Plan, a Retired Employee must satisfy the eligibility rules for Retired Participant coverage established and maintained by his or her Plan Sponsor. Any such additional Plan Sponsor requirements must be established and maintained pursuant to a written policy that is distributed to Employees and a copy of which is provided to the Plan Administrator upon request. Plan Sponsors may establish written policies for sharing the cost of Required Contributions for coverage with Retired Participants. Plan Sponsors have a duty to submit copies of such policies in a timely manner to the Plan Administrator, upon request.

(iv) *Cost-sharing by Plan Sponsors.* Notwithstanding the foregoing, Plan Sponsors may establish policies for sharing or subsidizing the cost of coverage (i.e., the Required Contributions) for Retired Participants under the Plan. Plan Sponsors must memorialize their cost-sharing policy in a written document that shall be: (1) submitted to the General Board upon request, (2) publicized through the Plan Sponsor's usual methods of communications, and (3) shared with Participants approaching Retirement.

3.06 Special Rules.

(a) A Plan Sponsor, with the written agreement of the General Board, may enroll other individuals in a category not specifically described above, provided that such category is one that may participate in a cafeteria plan (under §125 of the Code) and a Church Plan. Such individuals will be subject to all other terms of the Plan including the Risk Pool Rules.

(b) A person who is Disabled can participate in this Plan if he or she was a Participant at the time he or she became disabled. The Salary-Paying Unit or Plan Sponsor shall remain responsible for remitting Required Contributions for the coverage of the Disabled Participant. However, the Salary-Paying Unit or Plan Sponsor may separately arrange with the Disabled Participant the manner in which those costs are shared between them. In addition, a Disabled Participant may arrange with the General Board to pay the portion of Required Contributions for which he or she is responsible by deduction from his or her disability distributions from a disability plan administered by the General Board.

In addition, a person who is a Member of a Conference that is a Plan Sponsor of this Plan, who is Appointed to serve in another Conference that is not a Plan Sponsor of this Plan under ¶346.1 of *The Book of Discipline*, can participate in this Plan as a Disabled Participant if he or she must return to the Conference in which he or she is a Member for incapacity leave and disability plan benefits in accordance with *The Book of Discipline*, so long as (1) the Conference that is a Plan Sponsor remits the Required Contributions for coverage of the Disabled Participant, and (2) the Disabled Participant maintained

continuous creditable coverage under the Other Group Health Plan of the Conference to which he or she was Appointed.

(c) ***Family Leave.*** A Participant who is placed on maternity or paternity leave pursuant to ¶356 of *The Book of Discipline* shall continue his or her participation in the Plan on the same basis as immediately prior to being granted such leave for a period not less than 12 weeks.

(d) The Spouse and Dependents of a Participant shall be eligible for coverage under this Plan pursuant to:

(i) the rules established by the Plan Administrator;

(ii) the applicable Group Benefit Options; and

(iii) the choices elected by the Plan Sponsor on its Adoption Agreement.

A Plan Sponsor may elect, through its Adoption Agreement to offer coverage for the same-sex partner who has entered a civil union or domestic partnership, which, under the law of the state in which the Employee resides, provides the same substantive and procedural rights, privileges, and immunities as marriage. Such coverage shall be subject to the limitations of federal law, i.e., with respect to the Code, and the conditions described in Judicial Council Decision Nos. 1030, 1075 and 1264, and *The Book of Discipline*.

In accordance with the PPACA, beginning January 1, 2011, for any Benefit Option under the Plan that provides coverage to Dependent children of Participants, such Benefit Option will cover Participants' children who are under age 26. For the purposes of this Section 3.06(d), a "child" includes a Participant's or a Participant's Spouse's child, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom a Participant or his or her Spouse is the legal guardian.

(e) ***Continuation Coverage.*** The Plan Administrator shall establish appropriate rules and regulations with respect to continuation coverage taking into consideration applicable federal and state laws. Because the Plan is a Church Plan, it is exempt, pursuant to §4980B of the Code, from the requirements of COBRA. In no event, other than those permitted by law, such as in cases of gross misconduct by an Employee, will the Plan provide Terminated Participants Continuation Coverage less generous than that required by Illinois state law under ILCS 215/5 and 215/125. However, even if the Plan, in its discretion, offers continuation coverage in excess of applicable state law requirements that has attributes that resemble certain aspects of COBRA coverage, the Plan does not become subject to COBRA. In addition, the General Board, in its discretion, may extend Continuation Coverage offered to Terminated Employees beyond the term of the generally established rules for Continuation Coverage for certain reasons such as severance arrangements, settlement of litigation or satisfaction of other claims.

(f) A Plan Sponsor or an Employee may be excluded from continued participation in the Plan for failure to make Required Contributions on a timely basis. An Employee may also be excluded if the Salary-paying Unit that is responsible for making

Required Contributions on his or her behalf fails to make such Required Contributions.

(i) The Plan Administrator shall notify in writing, by certified mail with return receipt requested or by overnight commercial courier service (for next day delivery), the Plan Sponsor, the Salary-Paying Unit or the Employee of his or her failure to make Required Contributions on a timely basis.

(ii) If the Plan Sponsor fails to make the Required Contributions, namely payment in full of all outstanding Required Contributions, within 15 calendar days after the mailing of such Notice (where mailing includes placing the Notice with an overnight courier service for delivery), the Plan Sponsor shall cease to be a Plan Sponsor. Coverage will terminate effective on the first day of the month following the expiration of such 15-day period, subject to paragraph (iv) below.

(iii) If the Employee, or Salary-Paying Unit on behalf of such Employee, fails to make the Required Contributions, namely payment in full of all outstanding Required Contributions, within 15 calendar days after the mailing of such Notice (where mailing includes placing the Notice with an overnight commercial courier service for delivery), the Employee shall cease to be a Participant. Coverage will terminate effective on the first day of the month following the expiration of such 15-day period, subject to paragraph (iv) below.

(iv) The first day of the 15-day period described in paragraphs (ii) and (iii) above is the day after the Notice is mailed or placed with an overnight courier service for delivery. If payment is received by the Plan Administrator after the 15th day but before the first day of the following month, then:

(A) If such payment is the first late payment within the last 12 months, then a grace period will apply, and the termination of coverage described in paragraph (ii) or (iii) above will not be effective, but

(B) If such payment is the second (or later) late payment within the last 12 months, then a grace period will not apply, and the termination of coverage described in paragraph (ii) or (iii) above will be effective as provided therein, notwithstanding the receipt of the Required Contributions.

Once termination of coverage is effective, it may reinstated as provided in paragraph (v) or (vi) below.

(v) If a Plan Sponsor's coverage is terminated in accordance with paragraph (ii) above, such Plan Sponsor will not be eligible to re-adopt the Plan through an Adoption Agreement for a period of three (3) years after such termination.

(vi) If an Employee's coverage is terminated in accordance with paragraph (iii) above, such Employee will be able to re-enroll in the Plan during the next following Annual Election and Enrollment Period, if he or she meets the enrollment requirements of Article III above and any additional participation guidelines elected by the Plan Sponsor through its Adoption Agreement.

(vii) The termination of coverage under this Plan will not excuse a Plan Sponsor, Salary-Paying Unit or Employee from making payment in full for all Required Contributions due for any period that the Employee was covered under the Plan.

(viii) The Plan Administrator may establish a credit, payment plan and collection policy to implement or supplement the provisions of Section 3.06(f), which policy may include late fees, interest accruals, service charges and any other reasonable provisions designed to collect amounts due to the Plan or extend credit to a Plan Sponsor or Employee on reasonable terms. Generally, the General Board will assess a late payment penalty fee to Plan Sponsor Required Contributions that are past due. The late fee shall be equal to no less than an annualized interest rate of 10% (or the then-prevailing IRS-published underpayment rate, if higher) applied to the past due balance for the period of time the balance remains outstanding. The General Board may modify this policy in its discretion.

(g) ***Qualified Medical Child Support Orders.*** The Plan Administrator may determine that the Plan may provide benefits in accordance with the applicable requirements of any qualified medical child support order (a "QMCSO"), as defined in §609 of ERISA or other medical support order, including a National Medical Support Notice issued pursuant to the Child Support Performance and Incentive Act of 1998, that the Plan Administrator reasonably determines apply to the Plan, relating to the child of a Participant. The Plan Administrator or its agent shall pay benefits payable to a child covered by a QMCSO or other applicable support order directly to the child or to such child's parent or legal guardian, as the Plan Administrator determines is appropriate.

Article IV — Participant Accounts and Contributions

4.01 Provisions for Participant Accounts. The Plan Administrator shall maintain a Participant Account or Accounts for each Participant who participates in the Medical Reimbursement Account Program, the Dependent Care Account Program, or the Health Reimbursement Account. If a Participant elects to contribute to a Medical Reimbursement Account, the Administrator shall establish a Medical Reimbursement Account on behalf of that Participant. Likewise, if the Participant elects to contribute to a Dependent Care Account, the Administrator shall establish a Dependent Care Account on behalf of that Participant. If the Plan Sponsor elects to contribute to a Health Reimbursement Account, the Administrator shall establish a Health Reimbursement Account on behalf of that Participant. Collectively, the Medical Reimbursement Account, the Dependent Care Account, and the Health Reimbursement Account make up the Participant Accounts, and each separately is a Participant Account.

4.02 Crediting Participant Accounts. The Recordkeeper shall credit amounts to the Participant Accounts in accordance with Section 4.05 below.

4.03 Debiting Participant Accounts. The Recordkeeper shall debit each Participant Account in accordance with the rules of the Program in which the Participant is enrolled and pursuant to the direction of the Claims Administrator and Plan Administrator.

4.04 Nature of Participant Accounts. No money shall actually be allocated to any Participant Account; any such Account shall be of a memorandum nature, maintained by the Recordkeeper for the Plan and Plan Administrator's accounting purposes, and shall not be representative of any identifiable Trust assets. No interest will be credited to or paid on amounts credited to the Participant Accounts.

4.05 Source of Credits to Participants Accounts. Credits applied to the Participant Accounts shall be derived from the following sources.

(a) ***Active Employee Contributions.*** During the applicable Election Period or Annual Election Period determined under Article V, an Active Employee may enter into a salary reduction agreement with his or her Salary-Paying Unit. No money or other contributions shall be paid by any Active Employee to his or her Participant Accounts, other than as provided by this Article IV.

(b) ***Plan Sponsor Contributions:*** For any Period of Coverage, the Salary-paying Unit and Plan Sponsor shall make contributions on behalf of its Participants in an amount determined by the Plan Sponsor.

(i) Any such Plan Sponsor Contributions shall be made only on a nondiscriminatory basis within each category (i.e., Active Employee, basic or optional participation, and Lay Employee or Clergy Employee).

(ii) Notwithstanding anything to the contrary in this section, in making Plan Sponsor Contributions a Plan Sponsor may discriminate in favor of those Participants whose compensation is less than the Denominational Average Compensation provided that such discrimination is based upon a class of

individuals whose Compensation is below a specified amount (e.g., all Active Employees whose Compensation is less than *x* percent of the Denominational Average Compensation or whose Compensation is less than *y* dollars shall receive a larger Plan Sponsor Contribution).

4.06 Allocations Irrevocable During Period of Coverage. Except as provided in Section 5.07, the amounts to be credited to Participant Accounts during the Period of Coverage cannot be changed during the Period of Coverage.

Article V — Elections

5.01 In General. The Plan Administrator shall enact uniform and nondiscriminatory rules for making elections. Participants shall make their elections in accordance with these rules. The Plan Administrator shall provide, by electronic and written means, materials that contain information regarding the manner in which Participants may make elections prior to each Period of Coverage. Participants shall make such elections in the manner prescribed by the Plan Administrator. Elections, once made, shall be irrevocable and not subject to change for the Period of Coverage except as provided in Section 5.07.

5.02 Contributions and Benefits. Participants must designate the amount of the Participant Contributions and the Plan Sponsor Contributions, if any, to be allocated to the Medical Reimbursement Account and the Dependent Care Account for an elected Period of Coverage. Contributions allocated to a particular Benefit Option shall not be used for any other Benefit Option.

5.03 Period of Coverage. Except as provided in Sections 5.04 and 5.07, any Participant electing contributions and benefits must make an irrevocable election for an entire Period of Coverage.

5.04 Fractional Periods. A Participant who becomes eligible to participate in the middle of a Period of Coverage may elect to participate for a period lasting from the date on which he or she becomes eligible until the end of the then-current Period of Coverage. In such cases, the interval commencing the day after the elections are made and ending at the end of the then-current Period of Coverage shall be deemed to be the Period of Coverage. Such Participants must elect to participate no later than 30 days after becoming eligible to do so, i.e., within the Open Enrollment Period or within such other time limit as the Plan Administrator may prescribe.

5.05 Timing of Elections. Generally, elections of contributions and Group Benefit Options for a Period of Coverage shall be made prior to the Period of Coverage.

5.06 No Election. If a Participant fails to make an election relating to any coverage under the Plan on or before the specified due date for making such election and such Participant did not participate in the Plan the prior Plan Year, the Participant will not be able to participate in the Plan for the Plan Year. Except as otherwise specified by the Plan Administrator and communicated to Participants for a Plan Year, if a Participant elects coverage under a Group Benefit Option for a Plan Year but fails to make an election relating to any coverage under such Group Benefit Option for the immediately following Plan Year, the Participant shall be deemed to have elected the coverage under such Group Benefit Option that he or she elected for the prior Plan Year, provided that such coverage or comparable coverage, continues to be available under the Plan. A Participant shall be deemed not to have elected any amounts to be credited to a Medical Reimbursement Account or a Dependent Care Account as described in Section 7.03(b) and Section 8.03(b), respectively, for any subsequent Plan Year unless such Participant makes a new election for such Plan Year.

5.07 Changes of Elections or Commencement of Participation during a Plan Year.

(a) ***Change of Election.*** Elections with respect to coverage under the Plan shall be irrevocable by the Participant during the Period of Coverage; provided, however, that a Participant may revoke an election for the remainder of the Period of Coverage and file a new election, or an Employee who has otherwise satisfied the eligibility requirements set forth in Article III but has not heretofore elected to become a Participant in the Plan may elect to commence participation, only if: (1) both the revocation and the new election, or (2) the election to commence participation, as the case may be, is on account of and consistent with a Change in Status, as determined under this Section 5.07. A Participant is permitted to make Election changes, during a Period of Coverage, subject to the terms of Section 5.04 and only as provided in this Section 5.07. The determination of whether a revocation and new election or an election to commence participation is consistent with a Change in Status shall be determined by the Plan Administrator.

Any revocation of an election, new election or change in an election shall be made within 30 days after the occurrence of an event described below and in the manner prescribed by the Plan Administrator for such purposes and shall be effective as of the first day of the first month after the receipt of such election by the Plan Administrator, or such earlier time as required by law.

(b) ***Change in Status.*** A "Change in Status" shall include the following events:

(i) Change in the Employee's legal marital status;

(ii) Change in the number of the Employee's Dependents (as defined in §152 of the Code or Section 2.29 of the Plan);

(iii) Termination or commencement of employment by the Employee, not including an appointment change, or by the Spouse or a Dependent of the Employee;

iv) Strike or lockout affecting the employment status of the Employee or the Spouse or a dependent of the Employee;

(v) Change in the employment status of the Employee or the Spouse or a Dependent of the Employee that affects such person's eligibility under the Plan or an Other Group Health Plan;

(vi) Event that causes a Dependent of the Employee to satisfy or cease to satisfy the requirements for coverage due to attainment of a limiting age, loss of student status or any similar circumstances as provided in this Plan;

(vii) Change in the place of residence or work of the Employee or the Spouse or Dependent of the Employee that affects such person's eligibility under the Plan or an Other Group Health Plan;

(viii) Commencement of a special enrollment period under HIPAA, as set forth in §9801(f) of the Code;

(ix) Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order as defined in §609 of ERISA) that requires accident or health coverage for a child of the Employee (including a foster child who is a Dependent) or that requires the Employee's Spouse, former Spouse or other individual to provide coverage for a child of the Employee and such coverage is in fact provided by such individual;

(x) Employee or the Spouse or a Dependent of the Employee, who is enrolled in a Group Benefit Plan that is an accident or health plan, becomes entitled to or loses coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under §1928 of the Social Security Act, the program for the distribution of pediatric vaccines;

(xi) Such other events that the Plan Administrator determines will permit a change or revocation of an election or commencement of participation, during a Period of Coverage pursuant to Treasury Regulations or rulings issued under the Code.

(c) ***Certain Changes in Coverage.***

(i) If the cost of providing benefits under a Group Benefit Option or the Dependent Care Account Program is changed during a Plan Year and a Plan Sponsor elects not to pay some or all of the increase in such cost, or elects to apply any decrease to reduce a Participant's share of the cost under such Group Benefit Option or the Dependent Care Account Program, as the case may be, then the amount by which a Participant's compensation is reduced pursuant to a salary-reduction agreement shall be automatically adjusted consistent with the change in the cost to the Participant, as determined by the Plan Administrator.

(ii) A Participant shall be permitted to make a prospective election change with respect to his or her election (or decision not to make an election) to contribute to a Dependent Care Account or a Group Benefit Option for the remainder of the Plan Year if such change is on account of and corresponds with a change made under another employer-sponsored cafeteria plan or qualified benefits plan (as defined in applicable regulations), including the plan of the Participant's Plan Sponsor or of another employer provided that (i) the period of coverage under such other plan is different from the Plan Year, or (ii) the change made under such other plan is pursuant to applicable regulations under §125 of the Code.

(iii) During a Plan Year, an Eligible Person, or the Spouse or Dependent of an Eligible Person, who is not enrolled in the Plan shall be permitted to elect coverage under the Plan in a Group Benefit Option in accordance with the special enrollment rights under HIPAA, as provided in §9801(f) of the Code.

(d) Subsections a., b., and c. of this Section are intended to permit a change in election, new election or revocation of an election only in accordance with §125 of the Code and regulations and rulings thereunder, and shall be interpreted in accordance with

such intent. Accordingly, the Plan Administrator shall have the power to prescribe rules limiting an individual's right to make or revoke an election hereunder to the extent the Plan Administrator deems advisable in order to comply with §125 of the Code.

(e) ***Significant Cost Changes.*** If the Plan Administrator determines that the cost charged to a Participant (i.e., the Required Contribution for coverage) significantly increases during a Period of Coverage, the Participant may make a corresponding change in election under the Plan for the balance of the Period of Coverage, which will include (but not be limited to) the following:

(i) Significant Cost Increase. For a significant cost increase, Participants electing such coverage for the Period of Coverage may revoke their election and either elect a similar coverage for the balance of the Period of Coverage or drop such coverage if there is no similar coverage; or,

(ii) Significant Cost Decrease. For a significant decrease, Participants may elect to commence participation in the Benefit Option with the significant cost decrease and may make corresponding election changes regarding similar coverage for the balance of the Period of Coverage.

(f) ***Coverage Changes.*** In the case of a Benefit Option, if the Participant or his or her Spouse or Dependent experiences a significant curtailment in coverage, in the reasonable judgment of the Plan Administrator during the Period of Coverage, the Participant may make a corresponding change in election under the Plan for the balance of the Period of Coverage as follows:

(i) Significant Curtailment without Loss of Coverage. For a significant curtailment that is not a loss of coverage, the Participant electing such coverage for the Period of Coverage may revoke his or her election and elect a similar coverage for the balance of the Period of Coverage; or,

(ii) Significant Curtailment with Loss of Coverage. For a significant curtailment that is (or is deemed by the Plan Administrator to be) a loss of coverage, the Participant electing such coverage for the Period of Coverage may revoke his or her election and either elect a similar coverage for the balance of the Period of Coverage or drop such coverage if there is no similar coverage available.

(g) If during the Period of Coverage a new Benefit Option becomes available or an existing Benefit Option is significantly improved, Participants may elect the new or significantly improved Benefit Option, and may make corresponding election changes regarding similar coverage, for the balance of the Period of Coverage.

(h) In the event that a Participant's Spouse or Dependent makes an election change under a plan maintained by his or her employer, the Plan Administrator may permit the Participant to revoke an election under this Plan and make a new election for the balance of the Period of Coverage that is on account of and corresponds with the election change made by the Participant's Spouse or Dependent, if:

(i) §125 Election Change. The election change made by the Participant's Spouse or Dependent under his or her employer's plan satisfies the regulations and rulings under Code §125; or

(ii) Change in Period of Coverage. The period of coverage under the plan maintained by the employer of the Participant's Spouse or Dependent does not correspond with the Period of Coverage of this Plan.

(i) The Plan Administrator, in its sole discretion, on a uniform and consistent basis, will determine, in accordance with prevailing Internal Revenue Service guidance, whether the facts and circumstances of any of the events in this Section 5.07 have occurred.

(j) Any application for a revocation and new election under this Section 5.07 must be made within the time specified by the Plan Administrator following the date of the actual event and shall be effective at such time as the Plan Administrator shall prescribe, unless otherwise required by law.

(k) ***Consistency Rule.*** A Participant's requested revocation and new election under Section 5.07 will be consistent with a Change in Status if the election change is on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan or under a plan maintained by the employer of the Participant's Spouse or Dependent. A Change in Status that affects the eligibility under an employer's plan shall include a Change in Status that results in an increase or decrease in the number of a Participant's family members or Dependents who may benefit from coverage under the Plan.

(l) ***Automatic Termination of Election.*** Any election made under this Plan (including an election made through inaction under Section 5.06) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under a Benefit Option or other employee benefit plan may continue if and to the extent provided by such Benefit Option or plan. In the event such a former Participant again becomes a Participant before the end of the same Plan Year, the elections previously in effect for the Participant under the Plan shall be automatically reinstated for the balance of the Plan Year, if the former Participant has become a Participant again within 90 days of the termination of participation, except as otherwise elected by the Participant in accordance with Section 5.07.

(m) ***Maximum Elective Contributions.*** The maximum amount of elective Contribution under the Plan for any Participant shall be the maximum limits under Code §125 or such lower limit as the Plan Administrator may establish.

(n) ***Cessation of Required Contributions.*** Nothing in this Plan shall prevent the cessation of coverage or benefits under any Benefit Option, in accordance with the terms of such Benefit Option, on account of a Participant's failure to pay the

Participant's share of the cost of such coverage or benefits (i.e., his or her portion of the Required Contribution), through Compensation reduction or otherwise.

(o) ***Elections via Other Media.*** The Plan Administrator may, in its discretion, use any telephonic, electronic or other alternative media form that it deems necessary or appropriate for the election of benefits under the Plan.

(p) ***Dependent Care Account Program Coverage Changes.*** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in a Dependent Care Service Provider (as defined in Section 8.02). For example:

(i) if the Participant terminates one Dependent Care Service Provider and hires a new Dependent Care Service Provider, the Participant may change coverage to reflect the cost of the new service provider; and

(ii) if the Participant terminates a Dependent Care Service Provider because a relative, including the Spouse, becomes available to take care of the child at no charge, the Participant may cancel coverage.

(q) ***FMLA.*** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Plan Sponsor will continue to maintain the Participant's Group Health Plan Component coverage and Medical Reimbursement Account on the same terms and conditions as if the Participant were still an Active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Plan Sponsor will continue to pay its share of the Required Contribution.

A Participant may elect to continue his or her coverage under the Group Health Plan and Medical Reimbursement Account Program components of this Plan during the FMLA leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant shall pay his or her share of the Required Contributions in one of the following ways:

(i) with after-tax dollars, by sending monthly payments to the Plan Sponsor;

(ii) with pre-tax dollars, by pre-paying all or a portion of Required Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave compensation. To pre-pay the Required Contributions, the Participant must make a special election to that effect prior to the date that such compensation normally be made available; or

(iii) under another arrangement agreed upon between the Participant and the Plan Sponsor or Salary-Paying Unit (e.g., the Plan Sponsor or Salary-Paying Unit may fund coverage during the leave and withhold "catch-up" amounts upon the Participant's return).

If a Participant's coverage ceases while on FMLA leave, the Participant will be

permitted to re-enter the Plan upon return from such FMLA leave on the same basis the Participant was participating in the Plan prior to the FMLA leave, or as otherwise required by the FMLA.

If a Participant goes on a qualifying leave under the FMLA, entitlement to non-health benefits such as the Dependent Care Account Program will be determined by the Plan Sponsor's or Salary-Paying Unit's policy for providing such benefits when the Participant is on non-FMLA leave.

Article VI — Benefits

6.01 Benefits Available. A Plan Sponsor may make available to Participants the following Benefit Options:

(a) ***Medical Reimbursement Account Program*** (for Active Participants who are Employees only). This Benefit Option is defined in Article VII herein.

(b) ***Dependent Care Account Program*** (for Active Participants who are Employees only). This Benefit Option is defined in Article VIII herein.

(c) ***Premium Conversion Program***. Payment shall be made to the Plan or the appropriate insurer of amounts equal to the premiums, Required Contributions or their equivalent otherwise payable by (or on behalf of) the Participant during the Period of Coverage, for coverage of the Participant, or the Participant's Spouse or Dependents, under the programs maintained by the General Board pursuant to this Plan, as set forth below:

(i) Medical, Dental, Vision and Mental Health Group Benefit Options. The General Board maintains several comprehensive medical coverage, dental coverage and vision coverage Group Benefit Options in addition to mental health coverage Group Benefit Options. Each Participant, in accordance with the Group Benefit Options offered by his or her Plan Sponsor under the terms of its Adoption Agreement, shall have the right to elect to participate in one of the medical coverage Group Benefit Options and the mental health coverage Group Benefit Option and, if offered by his or her Plan Sponsor, in one of the available dental coverage Group Benefit Options and vision coverage Group Benefit Options. The terms and conditions for coverage under each of the medical, dental, vision and mental health Group Benefit Options is described in a separate HealthFlex Benefit Booklet, certificate of insurance or other benefit summary. Group Benefit Options may have additional rules and requirements for coverage, eligibility, payment of benefits, payment of premiums or Required Contributions, elections, continuation of coverage and termination.

Additionally, each Participant, in accordance with the Group Benefit Options offered by his or her Plan Sponsor under the terms of its Adoption Agreement, shall have the right to specify in his or her salary reduction agreement the amounts to be credited to his or her Medical Reimbursement Account or Dependent Care Account.

(ii) Other Benefit Programs. The General Board may offer from time to time other programs through a cafeteria plan, pursuant to §125 of the Code.

Subject to Section 6.02 below, each Participant shall have the option to select from among these Benefit Options subject to the terms of the Adoption Agreement of his or her Plan Sponsor. In the event of premium or Required Contribution changes that become effective during a Period of Coverage, a Participant's existing election as to a salary reduction shall automatically be adjusted to reflect the increases or decreases, as provided in Section 5.07(c)(i).

(d) ***Other Benefits.*** In the course of providing medical and other health care benefits pursuant to the Benefit Options, the Plan may also provide other benefits to Participants and their Dependents including, but not limited to, disease management programs, lifestyle and condition management programs and coaching, employee assistance programs, permitted incentive rewards for wellness initiatives, online access to health and wellness information, and other wellness benefits.

6.02 Terms and Limitation on Benefits. Coverage, benefit terms, exclusions and limitations for available Benefit Program benefits shall be as set forth in such Benefit Option's terms and conditions. The terms and conditions of the Medical Reimbursement Account Program are set forth in Article VII. The terms and conditions of the Dependent Care Account Program are set forth in Article VIII. The terms and conditions of the Group Benefit Options are set forth in the HealthFlex Benefit Booklet or certificate of insurance applicable to each Group Benefit Option. Appendix A provides a list of the Plan's Group Benefit Options and the documents that describe the terms, conditions, limitations and exclusions of each Group Benefit Option. The Plan Administrator shall update Appendix A from time to time as appropriate.

6.03 Claims for Benefits. Claims and the procedures for submitting and adjudicating Claims under available Benefit Options shall be governed by the terms of such Benefit Option's terms and conditions.

6.04 Post-termination Participation. Post-termination participation in available Benefit Options shall be governed by such Benefit Option's terms and conditions.

6.05 Rules and Regulations. The General Board shall establish all necessary rules, regulations, and procedures for the proper administration of any Group Benefit Option or Benefit Option established or offered hereunder. Any and all specific Group Benefit Options or Benefit Options may be created, amended or terminated by the General Board at any time in its sole discretion, provided that reasonable allowance is made for prior notification to the Plan Sponsors and Participants therein. The General Board is not required to notify Plan Sponsors or Participants of amendments necessitated by changes in applicable law or regulations.

6.06 Limitations. Notwithstanding any other provisions of the Plan, the Plan will make no payment for expenses incurred by an Employee, Spouse or Dependent:

(a) for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit;

(b) for or in connection with an illness or injury for which the Employee or Dependent is entitled to benefits under any workers' compensation or similar law;

(c) for charges made by a hospital owned or operated by or which provides care or performs services for the United States Government unless there is a legal obligation to pay such charges whether or not there is coverage;

(d) to the extent that payment is unlawful where the individual resides when the expenses are incurred;

(e) for charges that would not have been made if the individual had no coverage;

(f) to the extent that charges or expenses are more than the reasonable and customary charge or allowable amount as defined in the applicable Group Benefit Option description as determined by the Claim Administrator *(see Section 6.02, above)*;

(g) for charges or expenses that are not eligible expenses as determined by the Claim Administrator of a Benefit Option or Group Benefit Option;

(h) for charges or expenses that are not essential for medically necessary care and appropriate treatment of an illness or injury, as determined by the Claim Administrator;

(i) for or in connection with custodial services, education or training;

(ii) to the extent that an Employee, Spouse or any Dependents are in any way paid or entitled to payment for those expenses by or through a public program, sponsored, conducted or funded by any federal, state or local governmental entity, including Medicare (except when Medicare is assuming the role of secondary payer to this Plan for the individual), but not including Medicaid;

(i) for charges or expenses that are payable under any Other Group Health Plan, Other Health Coverage, or insurance or program to the extent described under Section 6.07 of this Plan;

(j) for or in connection with speech therapy if such therapy: (1) is used to improve speech skills that have not fully developed, (2) can be considered custodial or educational, or (3) is intended to maintain speech communication; speech therapy that is not restorative in nature will not be covered;

(k) for charges made by any provider who is a member of a Participant's family, a Dependent's family, or for charges made by any provider who shares a legal residence with the Participant or Dependent;

(l) for experimental, investigational or unproven services (or services in conflict with accepted medical standards) that are medical, surgical, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Claim Administrator to be:

(i) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal;

(ii) the subject of review or approval by an Institutional Review Board for the proposed use;

(iii) the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or

(iv) not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed;

(m) for treatment that is outside the scope of or inconsistent with a provider's license to treat;

(n) for cosmetic surgery or cosmetic dental work, unless such cosmetic surgery or dental work is for the treatment of an injury that occurred while the Employee, Spouse or Dependent was covered under the Plan, unless such cosmetic surgery or dental work qualifies as reconstructive surgery that is performed on the Employee, Spouse or Dependent following a surgical procedure when both the surgical procedure and the reconstructive surgery are medically necessary;

(o) for prescription medications used to prevent natural conditions such as baldness, including vitamins, Rogaine, etc.;

(p) for charges or expenses that are designed to be Employee, Spouse or Dependent expenses under the Group Benefit Options of this Plan, such as co-payments, coinsurance, deductibles and other out-of-pocket expenses, except to the extent such amounts are reimbursable expenses to a Participant under the Medical Reimbursement Account Program in Article VII;

(q) for or in connection with an injury or illness that is due to war, declared or undeclared, or acts of terrorism;

(r) for charges or expenses incurred outside the United States, unless the Employee, Spouse or Dependent is a U.S. resident and the charges are incurred while traveling;

(s) for non-medical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation;

(t) for medical treatment for a person age 65 or older, who is covered under this Plan as a working retiree but the Plan pays secondary under the Medicare Secondary Payer Rules, or their age 65 or older Dependent, when payment is denied by Medicare;

(u) for medical treatment when payment is denied by a primary plan *(see Section 6.07 below)* because treatment was received from a provider that is not a network or participating provider in the primary plan's network;

(v) for medical treatment when payment is denied by a primary plan (including Medicare; *see Section 6.07 below)* because treatment was not a covered service or covered expense under the primary plan, unless otherwise expressly covered by the Plan;

(w) for charges that an Employee, Spouse or Dependent is not obligated to pay or for which he or she is not billed or for which he or she would not have been billed except that they were covered under this Plan;

(x) for charges submitted more than 12 months from the date the charges are incurred;

(y) for medical and hospital care and costs for the infant child of a Dependent, unless that infant child is otherwise eligible under the Plan; and

(z) for charges for services and supplies that the Plan Administrator or Claim Administrator otherwise determine are excluded under the Plan.

Notwithstanding the foregoing, with respect to any Group Benefit Option that is fully-insured through an Insurer, the limitations of that Group Benefit Option according to the policy of insurance from the Insurer shall apply.

6.07 Coordination of Benefits. If a Participant or Dependent covered under this Plan is also covered under at least one Other Health Coverage, the Plan will coordinate the benefits payable for him or her from this Plan with the benefits payable for him or her from all Other Health Coverage.

(a) ***Generally.*** The Plan Administrator and Claim Administrator will use these Coordination of Benefits rules to determine the benefits payable for a Participant or Dependent for any Claim if the Claimant has health care coverage through one or more Other Group Health Plan or Other Health Coverage. The purpose of Coordination of Benefits is to ensure that there is no duplication of benefit payments. The total payment from this Plan as a secondary payer (as the Secondary Plan) will not, when added to the benefit paid by the primary plan (the Primary Plan), exceed what this Plan would have paid if it were the Primary Plan. Participants are obligated to inform the Plan Administrator or the Claim Administrator of the existence of Other Health Coverage.

(b) ***Prescription Drug Claims.*** This Section 6.07 Coordination of Benefits applies only to Claims for medical benefits. The Plan does not pay secondary benefits for prescription drug benefit Claims. If the Plan is not the Primary Plan, based on the rules below, with respect to a Claim for prescription drug benefits, then the Plan will pay for such a Claim pursuant to the applicable Group Benefit Option. If the Plan is the Secondary Plan, based on the rules below, with respect to a Claim for prescription drug benefits, then the Plan will not make any payment for such Claim.

(c) ***Other Group Benefit Option Claims.*** The Plan will apply the coordination of benefits rules related to Claims for mental health benefits and dental benefits in accordance with the HealthFlex Dental Benefits Booklet and the certificates of insurance for mental and behavioral health benefits. The Plan will apply coordination of benefits to Claims for vision benefits based on the rules described in the HealthFlex Benefit Booklets.

(d) ***Information.*** The Plan Administrator reserves the right to release to and obtain from any insurance company, other organization or person any information that, in the Plan Administrator's opinion, it needs for the purposes of Coordination of Benefits.

(e) ***Ordering Rules.*** To coordinate benefits, the Plan determines the payment responsibility or order for itself and the Other Health Coverage according to the following rules:

(i) The coverage under which the patient or Claimant is the eligible person or Participant (rather than a dependent) is the Primary Plan (meaning that full benefits are paid under that plan or program). The other coverage is the Secondary Plan and only pays any remaining eligible charges up to what the Secondary Plan would pay if it were the Primary Plan.

(ii) When a dependent child makes a Claim for covered services, the birthdays of the child's parents are used to determine which coverage is the Primary Plan. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be the Primary Plan. If both parents have the same birthday, then the coverage that has been in effect the longest is the Primary Plan. If the other coverage does not have this "birthday" type of Coordination of Benefits provision and, as a result, both coverages would be considered either the Primary Plan or the Secondary Plan, then the provisions of the other coverage will determine which coverage is the Primary Plan.

(A) However, when the parents are separated or divorced, and the parent with custody of the child has not remarried, the plan, contract or policy which covers the child as a dependent of the parent with custody of the child will be determined to be the Primary Plan paying before the benefits of a plan, contract or policy that covers the child as a dependent of the parent without custody;

(B) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract or policy that covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan, contract or policy that covers that child as a dependent of the stepparent, and the benefits of a plan, contract or policy that covers that child as a dependent of the stepparent will be determined to be the Primary Plan paying before the benefits of a plan, contract or policy that covers that child as a dependent of the parent without custody.

(iii) Notwithstanding the foregoing, if there is a court decree that would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan, contract or policy that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan, contract or policy that covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Plan Administrator and Claim Administrator and, upon their request, to provide a copy of such court decree.

(iv) If none of the above rules apply, then the coverage that has been in effect the longest is the Primary Plan.

(v) If the Other Health Coverage does not include a Coordination of Benefits provision, then, in all cases, the Other Health Coverage is the Primary Plan.

(f) The Plan Administrator and Claim Administrator have the right in administering these Coordination of Benefits provisions to:

(i) Pay any other organization an amount that they determine to be warranted if payments that should have been made by the Plan Administrator or Claim Administrator have been made by such other organization under any other group program; and

(ii) Recover any overpayment that the Plan Administrator or Claim Administrator may have made to a Participant, any provider, insurance company, person or other organization.

(g) ***Medicare.*** When coordinating benefits with Medicare, the Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Medicare Secondary Payer rules of the Social Security Act of 1965, as amended. However, when more than one plan is secondary to Medicare, the Plan Administrator and Claim Administrator will use the benefit determination rules identified above to determine how benefits will be coordinated.

(h) ***Recovery of Excess Benefits.*** If the Plan Administrator or Claim Administrator makes payments for benefits that should have been paid by a Primary Plan, or if the Plan Administrator or Claim Administrator makes payments in excess of those for which the Plan is obligated to provide under its terms, the Claim Administrator and Plan Administrator will have the right to recover the actual payment made, pursuant to a claim in equity, as held by the U. S. Supreme Court in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S. Ct. 1869 (2006). The Plan Administrator and Claim Administrator will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such payments were made by any insurance company, Group Health Plan or other organizations. Participants shall execute and deliver to the Plan Administrator or Claim Administrator such instruments and documents as it determines are necessary to secure the right of recovery.

6.08 Equitable Recovery. The Plan shall be subrogated for and, as permitted by the holding in *Sereboff* and under theories of equitable recovery based on an agreement between the Plan and individuals covered under the Plan, the Plan shall be entitled to, through an equitable lien based on such agreement, and shall succeed to all rights of recovery, for the reasonable value of any services and payments for benefits that the Plan has provided to Participants, Spouses and Dependents, from any or all of the following:

(a) Third parties including any person alleged to have caused a covered Participant or Dependent to suffer injuries or damages;

(b) Any person or entity who is or may be obligated to provide benefits or payments to a covered Participant or Dependent, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and

(c) Any person who or entity that is liable for payment to a covered Participant or Dependent on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

(d) A Participant shall:

(i) cooperate with the Plan in a timely manner in protecting the equitable rights to subrogation and reimbursement, including but not limited to:

(A) providing any relevant information requested by the Plan,

(B) signing and delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,

(C) responding to requests for information about any accident or injuries,

(D) appearing at depositions and in court, and

(E) obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.

(e) Failure by a Participant to cooperate in the manner described in Section 6.08(d) shall be deemed a breach of contract, and the Plan Administrator may terminate the coverage of the Participant or Dependent and institute legal action.

(f) Court costs and attorneys' fees shall not be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan shall not be required to participate in or pay court costs or attorneys' fees to the attorney hired by a Participant or Dependent to pursue his or her damage or personal injury claim.

(g) Regardless of whether a Participant or Dependent has been fully compensated or made whole, the Plan may collect from Participants and Dependents the proceeds of any full or partial recovery that a Participant or Dependent or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available in equity for the Plan's recovery shall include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment.

(h) Participants and Dependents are deemed to agree that if they receive any payment from any purportedly responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability) or judgment, the

Participant or Dependent will serve as a constructive trustee over the funds. Further, Participants and Dependents are deemed to agree that failure to hold such funds in trust will be deemed a breach of the Participant's or Dependent's duties hereunder.

(i) To the extent permitted by law, the Plan shall be entitled to recover reasonable attorneys' fees from a Participant or Dependent incurred in collecting from the Participant or Dependent any funds held by the Participant or Dependent that he or she recovered from any Third Party.

(j) To the extent permitted by law, the Plan may set off from any future benefits otherwise allowed and payable by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

(k) Participants and Dependents shall not accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Participant or Dependent do anything to prejudice the Plan's rights under this section.

(l) Participants will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Plan provided, plus reasonable costs of collection.

(m) The Plan's rights under this Section will be considered as the first priority claim against Third Parties, including tortfeasors (those liable for injuries) from whom Participants and Dependents are seeking recovery to be paid before any other of the Participant's or Dependents' claims are paid.

(n) The Plan's rights under this Section will not be reduced due to the Participant's or Dependent's negligence.

(o) The Plan may, at its discretion, take necessary and appropriate action to preserve its rights under this Section, including filing suit in the Participant's name. The Plan shall not be obligated, however, to pursue this right independently or on behalf of the Participant or Dependent.

(p) If the injury or condition that gives rise to subrogation or reimbursement involves a minor child, the terms of this Section shall apply to the parents or guardian of the minor child.

(q) If the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Participant or Dependent, this Section shall apply to the personal representative of the decedent.

Article VII — Medical Reimbursement Account Program

7.01 In General. The purpose of the Medical Reimbursement Account Program (Medical Reimbursement Program or MRA) is to enable Active Employees who elect to participate in the Medical Reimbursement Program to receive reimbursement or payment of certain health expenses subject to the terms, conditions, and limitations set forth herein. It is intended that the Medical Reimbursement Program qualify as an accident and health plan within the meaning of §105(e) of the Code and that the benefits payable under the Medical Reimbursement Program be eligible for exclusion from gross taxable income under §105(b) of the Code.

The Medical Reimbursement Program is unfunded, and any contributions to the Medical Reimbursement Program shall be considered a part of the general assets of the Plan Administrator. Nothing herein shall be construed to require the Plan Administrator to establish a trust or maintain any fund or segregate any amount for the benefit of any Participant in the Medical Reimbursement Program unless otherwise required by law. An Active Employee may elect to participate in this Medical Reimbursement Program by electing on an approved Form to:

(a) receive Benefits in the form of reimbursements for Medical Expenses; and

(b) pay the cost for such Benefits with before-tax Contributions that are allocated to the Participant's Medical Reimbursement Account.

7.02 Definitions. For purposes of this Article, the following special definitions shall apply:

(a) "Benefits" means reimbursement benefits for Medical Expenses under this Medical Reimbursement Account Program.

(b) "Dependent" means a dependent as defined in §152 of the Code. Any child to whom §152(e) or the Code applies shall be treated as a Dependent of both parents.

(c) "Grace Period" means the period from January 1 to March 15 following the end of the Plan Year to which it applies.

(d) "Medical Expenses" means expenses incurred by a Participant, a Participant's Spouse or a Participant's Dependents for medical care, as defined in §213(d) of the Code (without regard to the limitations contained in §213(a) of the Code) and applicable Treasury Regulations and Internal Revenue Service rulings, including amounts paid for hospital bills, doctor and dental bills, routine physical examinations, hearing aids, vision care, prescription drugs and insulin, non-prescription drugs and medicines (subject to the limitation described below), health insurance deductibles, co-payments or coinsurance payments, but only to the extent that: (1) the Participant submits a Claim for reimbursement of such expense during the Period of Coverage or the applicable Grace Period and Run-out Period described in Section 7.05 or the period described in Section 7.06; and (2) such expense is not covered, paid, or reimbursed under a Group Benefit Option or otherwise (i.e., through Other Health Coverage). Medical Expenses shall not include:

(i) an expense incurred for the payment of Required Contributions under the Plan or any premiums under an Other Group Health Plan, Other Health Coverage or health insurance plan; or

(ii) expenses for qualified long-term care services [as defined by §7702B(c) of the Code] and premiums for long-term care insurance.

Notwithstanding the foregoing, beginning January 1, 2011, pursuant to the PPACA, expenses for over-the-counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers) shall not be Medical Expenses for the purposes of Article VII and are not eligible for reimbursement, unless prescribed by a licensed health care provider.

7.03 Limitation on Benefits.

(a) ***Covered Expenses.*** The Medical Reimbursement Account Program shall only cover Medical Expenses incurred during the Period of Coverage and the applicable Grace Period, and shall only cover Medical Expenses incurred from Contributions made to this Medical Reimbursement Account Program by the Active Employee during such Period of Coverage. Medical Expenses shall be considered incurred when the medical care or service giving rise to the Medical Expense is provided and not when the Active Employee is billed, charged for or pays for the Medical Expenses.

(b) ***Amount of Benefits.*** The maximum amount that an Active Participant may elect to contribute to his or her Medical Reimbursement Account in any Plan Year shall be $2,500 pursuant to §125(i) of the Code, added by §9005 of the PPACA, or a lesser amount as determined by the Plan Administrator in accordance with applicable law. The minimum amount that an Active Participant may elect to contribute to his or her Medical Reimbursement Account in any Plan Year shall be $300 or as determined by the Plan Administrator in accordance with applicable law.

(c) ***Uniform Coverage.*** Reimbursement for Medical Expenses up to the amount elected by an Active Participant for a Period of Coverage shall be available at all times during the Period of Coverage (reduced by prior reimbursements during the Period of Coverage) regardless of the actual amounts by which an Active Employee's salary has been reduced and the amount that the Active Employee has contributed.

(d) ***Repayment of Excess Benefits.*** In the event that, as of the end of any Plan Year, the Plan Administrator determines that an Active Employee has received payments under this Plan that exceed the amount that Active Employee elected to contribute for that Plan Year, the Plan Administrator shall give the Active Employee prompt written notice of any such excess amount, and the Active Employee shall repay the amount of such excess to the Plan Administrator or Recordkeeper within 60 days of such notification.

(e) ***Forfeitures.*** Amounts that remain in a Participant's Medical Reimbursement Account shall be forfeit after payment of all timely presented eligible Claims for Medical Expenses incurred during the applicable Period of Coverage and applicable Grace Period, pursuant to Section 7.05, below. Forfeit amounts shall accrue to the Plan.

7.04 Eligibility, Enrollment and Termination. All Active Employees in the Plan may elect to contribute to a Medical Reimbursement Account under this Medical Reimbursement Account Program. Enrollment and termination of participation under the Plan shall constitute enrollment and termination of participation under this Medical Reimbursement Account Program.

7.05 Claims for Benefits.

(a) ***Claims for Reimbursement Benefits.*** Claims for Medical Reimbursement Account Program Benefits totaling a minimum amount as determined by the Plan Administrator may be made at any time during the Period of Coverage and applicable Grace Period.

(b) ***Prior Payment Unnecessary.*** Active Employees need not actually make payment for reimbursable Medical Expenses before being reimbursed for them under the Plan. However, the Plan Administrator may require verification that expenses have been incurred.

(c) ***Claim Substantiation.*** The Plan Administrator or Claim Administrator shall require an Active Employee to substantiate claims for Medical Reimbursement Account Benefits under the Plan by submitting an appropriate Claim Form to the Plan Administrator or Claim Administrator, in such manner and form as prescribed by the Plan Administrator or Claim Administrator, setting forth:

(i) the individual on whose behalf Medical Expenses have been incurred;

(ii) the nature and date of such Medical Expenses;

(iii) the amount of the requested reimbursement; and

(iv) a statement that such Medical Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

All Claims for Medical Expenses shall be substantiated by copies of invoices, explanations of benefits, bills, receipts or other statements, or electronic evidence from a provider or other third party showing that the Medical Expenses have been incurred, when they were incurred and the amount of such Medical Expenses, together with any additional documentation that the Plan Administrator or Claim Administrator may request.

(d) ***Time Limit on Claiming Benefits.*** The Plan Administrator shall only reimburse Claims for Medical Reimbursement Benefits if the Active Employee presents such Claims during the Period of Coverage or the applicable Grace Period. In addition, the Plan Administrator may reimburse eligible Claims submitted on or before April 30th of the year that follows the applicable Plan Year and its Grace Period. This additional time period is called the "Run-Out Period."

(f) ***Grace Period Claims.*** Medical Reimbursement Account claims incurred during a Grace Period shall be initially paid from the Medical Reimbursement Account established for

the Plan Year in which the expense was incurred, i.e., the Plan Year following the Plan Year to which the applicable Grace Period applies. Such Claims shall, however, be reallocated to the Medical Reimbursement Account established for the prior Plan Year, i.e., the Plan Year to which the applicable Grace Period applies, after the time period for submitting claims for the prior Plan Year under Section 7.05(d) has expired, to the extent of any balance in the Medical Reimbursement Account established for the prior Plan Year.

7.06 Reimbursements upon Termination of Participation.

(a) ***Termination of Participation on Account of Death.*** Upon the death of any Active Employee or Terminated Participant who has a credit balance in his or her Medical Reimbursement Account, the Spouse and Dependent children of the Participant may elect to continue to submit Claims for Medical Reimbursement Benefits under the deceased Participant's Medical Reimbursement Account in the same manner as the Active Employee or Terminated Participant could have done, up to the amount actually contributed to the Medical Reimbursement Account minus amounts previously paid pursuant to this Article. In the case of a deceased Active Employee, the Spouse and Dependents may submit Claims for reimbursement until the end of the Period of Coverage in which the Active Employee died plus the applicable Grace Period and Run-Out Period. In the case of a deceased Terminated Participant, the Spouse and Dependents may submit Claims for reimbursement up to the point in time that the deceased Terminated Participant otherwise could have submitted such Claims, i.e., 90 days from the date of Termination of Employment.

(b) ***Other Termination.*** An Active Employee who has a Termination of Employment for reasons other than death may no longer make Contributions nor have Contributions made to the Medical Reimbursement Account on his or her behalf. However, he or she may continue to receive Benefits under the Medical Reimbursement Account Program for Claims incurred prior to the Termination of Employment. Such Medical Reimbursement Benefit payments to a Terminated Participant shall be: (1) limited in amount to the balance remaining in the Terminated Participant's Medical Reimbursement Account at the time of Termination of Employment minus any subsequent reimbursements, and (2) limited in time to 90 days after the date of Termination of Employment. Claims submitted more than 90 days after Termination of Employment shall not be reimbursed; any amounts remaining in the Medical Reimbursement Account at the end of this post-termination Run-Out period shall be forfeited to the Plan pursuant to Section 7.03(e).

7.07 Rules and Regulations. The Plan Administrator shall establish all necessary rules, regulations and procedures for the proper administration of this Medical Reimbursement Account Program.

7.08 Annual Report to Members. The Plan Administrator or the Recordkeeper may furnish from time to time to each Active Employee or other Participant on whose behalf Medical Reimbursement Benefits are paid a written or electronic statement showing the amounts paid by the Plan in providing Medical Reimbursement Benefits on behalf of such Active Employee or other Participant during the Period of Coverage.

7.09 Recordkeeper. The General Board, in its discretion, may delegate administrative and recordkeeping duties with respect to the Medical Reimbursement Account Program to a third-party agent who shall be called the Recordkeeper of the Medical Reimbursement Account Program. The Recordkeeper shall account for the Medical Reimbursement Account balance of each Participant. The Recordkeeper may also serve as Claim Administrator for the Medical Reimbursement Account Program.

Article VIII — Dependent Care Account Program

8.01 In General. The purpose of the Dependent Care Account Program (DCA) is to enable eligible Employees to receive reimbursement of certain dependent care assistance expenses subject to the terms, conditions, and limitations set forth herein. It is intended that the Dependent Care Account Program qualify as a dependent care assistance program within the meaning of §129(d) of the Code and that the benefits payable under the Dependent Care Account Program be eligible for exclusion from gross income under §129(a) of the Code.

The Dependent Care Account Program is unfunded, and contributions shall be considered a part of the general assets of the General Board. Nothing herein shall be construed to require the General Board to establish a trust or maintain any fund or segregate any amount for the benefit of any Participant unless otherwise required by law. Participants covered by this Dependent Care Account Program may submit Claims for reimbursement of a Participant's eligible covered Dependent Care Expenses from Contributions allocated to the Participant's Individual Benefit Account for Dependent Care Benefits.

8.02 Definitions. For purposes of this Article VIII, the following special definitions shall apply:

(a) "Benefits" means reimbursement benefits for Dependent Care Expenses under this Dependent Care Program.

(b) Notwithstanding Section 2.28, for the purposes of this Article VIII the term "Dependent" means an individual who is:

(i) a dependent (as defined in §152 of the Code) of a Participant: (1) who is physically or mentally incapable of caring for himself or herself, or (2) who is under the age of 13 and with respect to whom the Participant is entitled to a deduction under §151(c) of the Code; or

(ii) a dependent (as defined in §152 of the Code) of the Spouse of a Participant, who is physically or mentally incapable of caring for himself or herself.

(c) "Earned Income" means wages, salaries, tips and other compensation, plus net earnings from self-employment, computed without regard to any community property laws and excluding amounts received as a pension or annuity, or paid or incurred by an employer for dependent care assistance. A Participant's Spouse who is either a student or physically or mentally incapable of caring for himself or herself shall be deemed, for each month during which such Spouse is either a full-time student at an educational institution or physically or mentally incapable of caring for himself or herself, to be gainfully employed and to have Earned Income of not less than:

(i) $250 per month, if the Participant has only one Dependent for the Period of Coverage; or

(ii) $500 per month, if the Participant has two or more Dependents for the Period of Coverage; or

(iii) such other dollar amounts as may be permitted under §21(d) of the Code which are hereby incorporated into the Dependent Care Account Program by reference.

(d) "Dependent Care Expenses" means expenses incurred by a Participant during a Period of Coverage that are: (1) incurred for the care of a Dependent of the Participant or for related household services; (2) paid or payable to a Dependent Care Service Provider; (3) incurred to enable the Participant to be gainfully employed for any period during which there are one or more Dependents with respect to the Participant. Dependent Care Expenses shall not include any expenses for which: (1) the Participant does not submit a Claim for reimbursement within the 90-day period following the end of the Period of Coverage; (2) a deduction or credit is claimed on the Participant's income tax return; (3) reimbursement or payment is received under another dependent care assistance program (other than this Dependent Care Account Program); or (4) expenses are incurred for services performed outside the Participant's household for the care of a Dependent unless such Dependent is described in Section 8.02(b)(ii), above, or regularly spends at least eight hours each day in the Participant's household; provided, however, such terms shall not include any amount paid for services outside the Participant's household at a camp where the Dependent stays overnight. Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

(e) "Dependent Care Service Provider" means an individual operating a dependent care center (as defined in §21(b)(2)(D) of the Code) that: (1) receives a fee or grant for providing services described in Section 8.02(d) to six or more individuals (other than individuals who reside at the dependent care center); and (2) complies with all applicable laws and regulations of a State or local government (as required by §21(b)(2)(D) of the Code). A Dependent Care Service Provider shall not include an individual (as defined in §129(c) of the Code) who is: (1) a dependent with respect to whom the Participant or the Participant's Spouse is entitled to claim an exemption under §151(c) of the Code; or (2) a son, daughter, stepson or stepdaughter of the Participant under the age of 19.

8.03 Limitation on Benefits.

(a) ***Coverage.*** The Dependent Care Account Program shall only cover Dependent Care Expenses incurred during the Period of Coverage and only from Contributions made to this Dependent Care Account Program by the Active Employee during such Period of Coverage. Dependent Care Expenses shall be considered incurred when the Dependent care is provided, and not when the Participant is formally billed or charged for or pays the Dependent Care Expenses.

(b) ***Amount of Benefits.*** If an Active Employee elects to contribute to a Dependent Care Account, the minimum amount that the Active Employee may elect to contribute to his or her Dependent Care Account for any Period of Coverage shall be $300 or as determined by the Plan Administrator in accordance with applicable law. The maximum amount that an Active Employee can elect to contribute to his or her Dependent Care Account for a Period of Coverage shall be $5,000 (unless the Active Employee is married but filing income tax returns separately from his or her Spouse, in which case the maximum amount shall be $2,500) or as determined by the Plan Administrator in accordance with applicable law. The amount payable for a particular Dependent Care

Account Program Benefit at any time may not exceed the balance of the Participant's Dependent Care Account at the time the Participant submits his or her Claim for such Benefit. If Claims for amounts in excess of such balance are made at any time, such claims may be paid when and if further Employee Contributions or Plan Sponsor Contributions allocable to such Participant's Dependent Care Account are made during the applicable Period of Coverage.

(c) ***Repayment of Excess Benefits.*** If at any time during the Period of Coverage, the Plan Administrator determines that an Active Employee has received payments under this Dependent Care Account Program that exceed the amount the Active Employee has contributed to his or her Dependent Care Account, the Plan Administrator shall give the Active Employee prompt written notice of any such excess amount, and the Active Employee shall repay the amount of such excess to the Plan Administrator or Recordkeeper within 60 days of such notification.

(d) ***Forfeitures.*** Amounts that remain in a Dependent Care Account after the end of the Plan Year and the applicable Run-out Period, i.e., April 30 following the end of the Plan Year, shall be forfeit to the Plan. Forfeit amounts shall accrue to the Plan.

8.04 Eligibility, Enrollment and Termination. All Active Employees in the Plan may elect to contribute to a Dependent Care Account under this Dependent Care Account Program. Enrollment and termination of participation under the Plan shall constitute enrollment and termination of participation under this Dependent Care Account Program.

8.05 Further Limitations. The amount of Benefits payable to a Participant during any Plan Year shall not exceed:

(a) in the case of a Participant who is not married at the close of such year, the Earned Income of such Participant for such year; or

(b) in the case of a Participant who is married at the close of such Plan Year, the lesser of:

(i) The Earned Income of such Participant for such year; or

(ii) The Earned Income of the Spouse of such Participant for such Plan Year.

8.06 Prohibition of Certain Payments. No Benefits shall be paid to a Participant during any taxable year of such Participant to reimburse Dependent Care Expenses paid to an individual:

(a) with respect to whom, for such taxable year, a deduction is allowable under Code §151(e) (relating to personal exemptions for Dependents) to such Participant or his or her Spouse; or

(b) who is a child of such Participant [within the meaning of Code §151(e)(3)] under the age of 19 at the close of such taxable year.

8.07 Services Outside the Household.

(a) ***Dependent Care Centers.*** Benefits shall be paid for services provided outside a Participant's household by a facility that provides care for more than six individuals other than individuals who reside at the facility, and receives a fee, payment or grant for providing services for any of the individuals, only if:

(i) such facility complies with all applicable laws and regulations of a state or unit of local government; and

(ii) the requirements of Section 8.07(b) are met.

(b) ***Certain Dependents.*** Benefits shall not be paid for services outside a Participant's household unless the services are provided for the care of: (1) a Dependent within the meaning of Section 8.02(b)(i); or (2) any other Dependent who regularly spends at least eight hours each day in the Participant's household.

8.08 Claims for Benefits.

(a) ***Claims for Reimbursement Benefits.*** Claims for Dependent Care Benefits may be made at any time during a Period of Coverage and the applicable Run-out Period.

(b) ***Prior Payment Unnecessary.*** Participants need not actually make payment for reimbursable Dependent Care Expenses before being reimbursed for them under the Dependent Care Account Program. However, the Plan Administrator may require verification that Dependent Care Expenses have been properly incurred.

(c) ***Claim Substantiation.*** The Plan Administrator or its agent shall require a Participant to substantiate Claims for Dependent Care Account Program Benefits under the Plan. Claimants shall substantiate all Claims for reimbursement of Dependent Care Expenses with copies of bills or receipts. Where necessary and appropriate, the Plan Administrator may in its discretion waive such requirements, but in so doing shall always act in a uniform and nondiscriminatory manner.

(d) ***Time Limit on Claiming Benefits.*** The Plan Administrator shall only reimburse Claims for Dependent Care Account Program Benefits if the Participant presents such Claims within 90 days after the end of the Period of Coverage, or within such other reasonable time limits prescribed by the Plan Administrator.

8.09 Annual Report to Members. The Plan Administrator or the Recordkeeper may furnish from time to time to each Participant on whose behalf Dependent Care Benefits are paid a written statement showing the amounts paid by the Plan in providing Dependent Care Benefits on behalf of such Participant during the Period of Coverage.

8.10 Post-Termination. Post-termination participation shall be determined in accordance with the rules and regulations established by the Plan Administrator. Generally, an Active Employee who has a Termination of Employment for reasons other than death may no longer make Contributions nor have Contributions made to the Dependent Care Account on his or her behalf. However, he or she may continue to receive Benefits under the Dependent Care

Account Program for Claims incurred prior to the Termination of Employment. Such Dependent Care Account Program Benefit payments to a Terminated Participant shall be: (i) limited in amount to the balance remaining in the Terminated Participant's Dependent Care Account at the time of Termination of Employment minus any subsequent reimbursements; and (ii) limited in time to 90 days after the date of Termination of Employment. Claims submitted more than 90 days after Termination of Employment shall not be reimbursed; any amounts remaining in the Dependent Care Account at the end of this post-termination Run-out Period shall be forfeit to the Plan pursuant to Section 8.03(d).

8.11 Rules and Regulations. The Plan Administrator shall establish all necessary rules, regulations, and procedures for the proper administration of this Dependent Care Account Program.

8.12 Recordkeeper. The General Board, in its discretion, may delegate administrative and recordkeeping duties with respect to the Dependent Care Account Program to an agent which shall be called the Recordkeeper of the Dependent Care Account Program. The Recordkeeper shall account for the Dependent Care Account balance of each Participant. The Recordkeeper may also serve as Claim Administrator for the Dependent Care Account Program.

Article IX – Health Reimbursement Accounts

9.01 In General. A Health Reimbursement Account (HRA, also called a Health Reimbursement Arrangement) is intended to permit an eligible HRA Participant, as described in Section 9.04 below, to obtain reimbursement of Medical Care Expenses from the HRA on a nontaxable basis. Capitalized terms used in this Article IX that are not otherwise defined in the Plan shall have the meanings set forth in Section 9.03.

9.02 Legal Status. The HRA is intended to qualify as an employer-provided medical reimbursement plan under Code §105 and Code §106 and the Treasury Regulations issued thereunder, and as a health reimbursement arrangement as defined under *IRS Notice 2002-45*, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the HRA are intended to be eligible for exclusion from HRA Participants' gross income under Code §105(b).

9.03 Definitions.

(a) "Benefits" means the reimbursement benefits for Medical Care Expenses described under Section 9.04.

(b) "Continuation Coverage" means the coverage offered under the Plan generally for Participants who lose eligibility or otherwise terminate coverage under the Plan, described in Section 3.06(e) of the Plan.

(c) "CDHP or Consumer-Driven Health Plan" means a Benefit Option under the Plan described in Section 2.14 of the Plan.

(d) "Effective Date" of this Article IX and the HRA is January 1, 2011.

(e) "Eligible Employee" means an Employee as described in Section 2.35 of the Plan eligible to participate in the Plan, as described in Article III, covered in a CDHP under the Plan or another HRA-eligible Benefit Option as determined by the Administrator and the elections of the Plan Sponsor in its Adoption Agreement, and eligible to participate in the HRA, as provided in Section 9.04.

(f) "Employee" means Employee as defined in Section 2.35 of the Plan.

(g) "Employer" for the purposes of the HRA and this Article IX means either the Plan or a Participant's Plan Sponsor.

(h) "FMLA" means the Family and Medical Leave Act of 1993, as amended.

(i) "Health FSA" means the health flexible spending arrangement (health flexible spending account) as defined in Proposed Treasury Regulation §1.125-2, Q/A-7(a), called the Medical Reimbursement Program (or Medical Reimbursement Account or MRA) and described in Article VII.

(j) "HRA" means a health reimbursement arrangement (health reimbursement account) as defined in *IRS Notice 2002-45* and described in Sections 2.50 and 9.05 of the Plan.

(k) "HRA Administrator" means the General Board of Pension and Health Benefits (General Board). .

(l) "HRA Claims Administrator" means the third-party claims processing administrator chosen and engaged by the General Board. The General Board may change the HRA Claims Administrator at any time without notice to Participants. The HRA Claims Administrator and the Medicare Connector HRA Claims Administrator may be separate entities.

(m) "HRA Dependent" means any individual who qualifies as an eligible dependent of a Participant under a CDHP or other HRA-eligible Benefit Option under the Plan. Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child or eligible spouse does not meet the definition of "Dependent." The HRA does not cover Medical Care Expenses of dependents as defined in Code §152 who are not covered in a CDHP or other HRA-eligible Benefit Option under the Plan.

(n) "HRA Participant" means a person who is an Eligible Employee and who is participating in: (i) a CDHP under the Plan, or (ii) another HRA-eligible Benefit Option as determined by the Administrator and the election of the Plan Sponsor on its Adoption Agreement, *and* (iii) an HRA in accordance with the provisions of this Article IX.

(o) "Medical Care Expenses" has the meaning defined in Section 9.06(a).

(p) "Period of Coverage" means the Plan Year generally, and may mean the period from the date of enrollment in the HRA to the end of the then-current Plan Year for an HRA Participant who becomes eligible during a Plan Year.

(q) "Plan" means HealthFlex.

(r) "Plan Year" means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31).

(s) "QMCSO" means a qualified medical child support order, as defined in ERISA §609(a) and Section 3.06(h) of the Plan.

(t) "Retiree HRA" (RHRA) means the post-termination health care reimbursement arrangement maintained by the General Board described in Section 9.06(f). Retiree HRAs do not include and are separate from the Medicare Connector HRAs described in Article X.

(u) "Retired HRA Participant" means a former Employee who remains an "HRA Participant" for only the limited purpose of continued eligibility for benefits in retirement in accordance with Section 9.06(f). Retired HRA Participant excludes Medicare Connector HRA Participants who were not Retired HRA Participants before their Plan Sponsor adopted the Medicare Connector Program.

(v) "Spouse" means an individual who is legally married to an HRA Participant or Retired HRA Participant as determined under applicable state law (and who is treated as a spouse under the Code or is otherwise permitted to be covered in an HRA under *IRS Notice 2002-45* and other IRS guidance). To be eligible under the HRA for claims reimbursement, an HRA Participant's Spouse must also be covered in a CDHP under the Plan or in another HRA-eligible Benefit Option as determined by the Administrator and the election of the Plan Sponsor. Expenses incurred by Spouses who are not covered in a CDHP or other HRA-eligible Benefit Option under the Plan are not eligible for reimbursement.

(w) "SPD" means the HealthFlex *Summary Plan Description* describing the terms of the Plan and this HRA.

(x) "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

9.04 Eligibility to Participate. An individual is eligible to participate in the HRA if he or she is a Participant in the Plan and has elected and is enrolled in a CDHP or other HRA-eligible Benefit Option, as determined by the Administrator and the Plan Sponsor's elections on its Adoption Agreement, under the Plan. Once the General Board has determined that an Employee has met the HRA's eligibility requirements, the Employee's coverage in the HRA will commence.

(a) ***Termination of Participation*.** A Participant will cease to be an HRA Participant in the HRA upon the earliest of:

(i) The termination of the Plan or the HRA; or

(ii) The date on which the HRA Participant becomes a Terminated Participant as described in Section 2.90 or incurs a Termination of Employment, provided that eligibility may continue beyond such date for purposes of Continuation Coverage,

as may be permitted by the General Board on a uniform and consistent basis under Section 9.06(h); or

(iii) The date on which the HRA Participant elects to discontinue participation in a CDHP or other HRA-eligible Benefit Option under the Plan when a CDHP or other HRA-eligible Benefit Option is offered by his or her Plan Sponsor; or

(iv) The date on which a HRA Participant who is a Clergy Employee is appointed to a Plan Sponsor that does not offer a CDHP or other HRA-eligible Benefit Option as a Benefit Option; or

(v) The date on which the Employee's HRA balance becomes zero ($0) as a result of forfeiture.

Reimbursements from the Plan after termination of participation will be made pursuant to Section 9.06(e) and (h).

(b) ***Participation Following Termination of Employment or Loss of Eligibility.*** If a Participant becomes a Terminated Participant for any reason (including but not limited to disability, retirement, layoff or voluntary resignation) and then is rehired, the Participant will be considered a new HRA Participant.

(c) ***FMLA and USERRA Leaves of Absence.*** Notwithstanding any provision to the contrary in this Article, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the General Board will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Employee.

(d) ***Non-FMLA and Non-USERRA Leaves of Absence.*** If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described above under Section 9.04(a).

(e) ***Effective date of Participation.*** An Employee who first becomes eligible to participate in the HRA will commence participation on the first day after the eligibility requirements have been satisfied. Once enrolled, the Employee's participation will continue year-to-year until the Employee's participation ceases pursuant to Section 9.04(a).

9.05 Benefits Offered. When an Eligible Employee becomes an HRA Participant in accordance with Section 9.04, an HRA will be established for such Participant to receive HRA Benefits in the form of reimbursements for Eligible Medical Care Expenses, as described in Section 9.06. In no event shall HRA Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Medical Care Expenses.

(a) ***Employer and Participant Contributions***

(i) *Employer Contributions.* Contributions from the Plan and, if applicable, from the Plan Sponsor (i.e., the Employer for purposes of the HRA) shall fund the full amount of the HRAs.

(ii) *Participant Contributions.* Participant contributions to HRAs are not permitted.

(iii) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions or otherwise under a cafeteria plan.

(iv) *Administrative Expenses.* Necessary administrative expenses may be deducted from the Participant's account balance.

(b) ***Funding.*** All of the amounts payable under the HRA [other than the administrative expenses outlined in Section 9.05(a)(iv)] shall be paid from the general assets of the Plan, or applicable Plan Sponsor. Nothing herein will be construed to require the General Board or any Plan Sponsor to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the General Board, Plan or Plan Sponsor from which any payment under the HRA may be made. HRAs are not held in trust, nor are HRA Benefits paid from the Employee Benefit Trust of The United Methodist Church or any other trust.

9.06 HRA Benefits. The HRA will reimburse HRA Participants for Eligible Medical Care Expenses up to the unused amount in the Participant's HRA, as set forth and adjusted under Section 9.06(d).

(a) Eligible Medical Care Expenses. Under the HRA, an HRA Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage. The following apply:

(i) *Incurred.* An Eligible Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays

for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not Eligible Medical Care Expenses.

(ii) *Eligible Medical Care Expenses Generally.* "Eligible Medical Care Expenses" means expenses incurred by an HRA Participant or his or her Spouse or HRA Dependents for medical care, as defined in Code §213 (including, for example, amounts for certain hospital bills, doctor and dental bills, and prescription drugs). Additionally and *only with respect to Retired HRA Participants with RHRA Accounts,* Eligible Medical Care Expenses include premiums for long-term care insurance; individual health, dental and vision insurance policies; and Medicare Part B. Eligible Medical Care Expenses shall not include expenses described in Section 9.06(b) for any Participant. Reimbursements due for Eligible Medical Care Expenses incurred by the HRA Participant or the HRA Participant's Spouse or HRA Dependents shall be charged against the HRA Participant's HRA.

(iii) *Eligible Medical Care Expenses Exclusions.* "Eligible Medical Care Expenses" shall not include the expenses listed as exclusions under Section 9.06(b).

(iv) *Expenses Cannot Be Reimbursed or Reimbursable from Another Source.* Eligible Medical Care Expenses can only be reimbursed to the extent that the HRA Participant or other eligible person incurring the Eligible Medical Care Expense is not reimbursed for the expense (nor is the expense reimbursable) through the CDHP, other Benefit Option under the Plan, other insurance, or any other accident or health plan. Notwithstanding the preceding sentence, if the "other health plan" is the Health FSA, Section 9.06(j) shall govern the reimbursement. If only a portion of an Eligible Medical Care Expense has been reimbursed elsewhere (e.g., because the CDHP, other Benefit Option, or other coverage or insurance imposes co-payment, coinsurance or deductible limitations), the HRA can reimburse the remaining portion of such Eligible Medical Care Expense if it otherwise meets the requirements of this Section 9.06(a).

(b) ***Exclusions—Medical Care Expenses That Are Not Reimbursable.*** Certain expenses *are not reimbursable* under the HRA, even if they meet the definition of "medical care" under Code §213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs. *The following expenses are not reimbursable*:

(i) Premiums that a Participant pays under any individual health plan or individual health insurance policy; and premiums that a Participant pays for employer-sponsored group plan coverage. [However, Premiums that Retired HRA Participants with Retiree HRA (RHRA Accounts) pay may be reimbursable to the extent permitted under Section 9.06(a)(ii)].

(ii) Continuation coverage premiums.

(iii) Premiums that a Participant pays for disability insurance.

(iv) Long-term care services [with the exception of Retired HRA Participants with RHRA Account, as noted in Section 9.06(a)(ii)].

(v) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

(vi) Over-the-counter, non-prescription drugs and medicines for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless they are prescribed by a licensed health care provider.

(vii) The salary expense of a nurse to care for a healthy newborn at home.

(viii) Funeral and burial expenses.

(ix) Household and domestic help (even though recommended by a qualified physician due to an individual's inability to perform physical housework).

(x) Massage therapy, not covered by a Benefit Option under the Plan (unless prescribed by a doctor to treat a medical condition).

(xi) Home or automobile improvements.

(xii) Custodial care.

(xiii) Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.

(xiv) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.

(xv) Social activities, such as dance lessons (even though recommended by a physician for general health improvement).

(xvi) Bottled water.

(xvii) Maternity clothes.

(xviii) Diaper service or diapers.

(xix) Cosmetics, toiletries, toothpaste, etc.

(xx) Vitamins and food supplements, unless prescribed by a physician for a specific medical condition.

(xxi) Uniforms or special clothing, such as maternity clothing.

(xxii) Automobile insurance premiums.

(xxiii) Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

(xxiv) Any item that does not constitute "medical care" as defined under Code §213.

(c) ***Maximum Benefits.***

(i) *Maximum Benefits.* The maximum annual dollar amount that may be credited to an HRA Account for a HRA Participant for an entire Period of Coverage shall be as determined under the applicable policy established by the General Board annually before the beginning of each Plan Year. In addition, the HRA Participant's Plan Sponsor may contribute Employer contributions to the HRA Participant's HRA Account under its own written policy that is uniform and nondiscriminatory among the Plan Sponsor's HRA Participants. Unused amounts may be carried over to the next Period of Coverage, as provided in Section 9.06(e).

(ii) *Changes.* For each Plan Year, the maximum dollar limit may be changed once annually by the General Board and shall be communicated to HRA Participants and Eligible Employees through an enrollment form, other enrollment and Annual Election materials, the *Summary Plan Description* (SPD) or another document. In addition, a Plan Sponsor may, in its discretion, contribute additional Employer contributions to its HRA Participants' HRA Accounts on a uniform and nondiscriminatory basis pursuant to established Plan Sponsor policies.

(d) ***Establishment of Account.*** The General Board will establish and maintain an HRA with respect to each HRA Participant but will not create a separate fund or otherwise

segregate assets for this purpose. The HRA so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(i) *Crediting of Accounts.* At the beginning of each Plan Year the HRA Participant will receive a contribution, as determined by the General Board and, if applicable, the Plan Sponsor, to the HRA Participant's HRA.

(ii) *Debiting of Accounts.* A HRA Participant's HRA will be debited during each Period of Coverage for any reimbursement of Eligible Medical Care Expenses incurred during the Period of Coverage and, if necessary, for administrative expenses.

(iii) *Available Amount.* The amount available for reimbursement of Eligible Medical Care Expenses is the amount credited to the Participant's HRA under Section 9.06(d)(i) reduced by prior reimbursements debited under Section 9.06(d)(ii) and any administrative expenses.

(e) ***Carryover of Accounts.*** If any balance remains in the Participant's HRA for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the HRA Participant for Eligible Medical Care Expenses incurred during a subsequent Period of Coverage.

The HRA Participant's coverage will terminate upon Termination of Employment, becoming a Terminated Participant or other loss of eligibility and all Eligible Medical Care Expenses incurred up until such time shall be eligible for reimbursement under the terms of this Article IX. If any balance remains in a Terminated or ineligible Participant's account, the funds will be handled in the subsequent Plan Year in the following way:

(i) If the HRA Participant has a positive HRA balance and retires in accordance with all the retirement eligibility rules of the Plan and those of his or her Plan Sponsor (i.e., becomes a Retired Participant in the Plan and a Retired HRA Participant), his or her HRA balance shall be transferred to a Retiree HRA described in Section 9.06(f).

(ii) If the HRA Participant elects to discontinue participation in a CDHP or other HRA-eligible Benefit Option under the Plan when a CDHP or other HRA-eligible Benefit Option is offered by his or her Plan Sponsor, or if the Plan Sponsor no longer offers a CDHP Benefit Option or other HRA-eligible Benefit Option, the HRA Participant shall have 365 days to spend-down (i.e., both incur and be reimbursed for Eligible Medical Care Expenses) his or her HRA balance. However, the HRA Participant will not be eligible for any additional Employer contributions upon discontinuation in the CDHP or other HRA-eligible Benefit

Option. After the 365-day spend-down period, any remaining balances shall be forfeited to the Plan.

(iii) If the HRA Participant becomes a Terminated Participant as described in Section 2.90, or otherwise incurs a Termination of Employment, any remaining balance shall be available for reimbursement as described in Section 9.06(h), unless the HRA Participant opts out of the HRA pursuant to Section 9.06(i). However, if the individual is a Participant on Continuation Coverage, the remaining balance shall be available for reimbursement for the duration of the individual's Continuation Coverage period. In addition, any Plan benefit payments for the Terminated Participant that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Eligible Medical Care Expense was incurred shall be forfeited.

(iv) If the HRA Participant is a Clergy Employee who is appointed to a Plan Sponsor that does not offer a CDHP or other HRA-eligible Benefit Option (or to a Conference that does not participate in the Plan), any remaining balance shall be suspended and frozen until such Participant returns to a Plan Sponsor offering a CDHP or other HRA-eligible Benefit Option or becomes a Terminated Participant. If such a Participant returns to a Plan Sponsor offering a CDHP or other HRA-eligible Benefit Option, his or her suspended HRA balance again becomes available for reimbursement. If the HRA Participant becomes a Terminated Participant, Section 9.06(e)(iii) shall apply.

(f) ***Retiree HRA.*** An HRA Participant who retires as described in Section 9.06(e)(i) and pursuant to the retirement eligibility rules of the Plan and his or her Plan Sponsor shall have any remaining balance in his or her HRA converted and transferred to a Retiree HRA. A Retired HRA Participant may be reimbursed from his or her Retiree HRA for Eligible Medical Care Expenses [as described in Section 9.06(a)] until such Retiree HRA is exhausted. Amounts are carried over from Plan Year to Plan Year as long as the Retired HRA Participant remains retired and has not died. Upon the death of a Retired HRA Participant, if such deceased Retired HRA Participant has an eligible surviving Spouse or eligible surviving HRA Dependents, the eligible survivors may be reimbursed from the Retiree HRA of the deceased Retired HRA Participant for Eligible Medical Care Expenses until the earliest of the following: such Retiree HRA is exhausted, such survivors die, or such survivors have ceased to be Participants in a Benefit Option for more than one (1) year. If a Retired HRA Participant dies with a balance in his or her Retiree HRA and has no eligible surviving Spouse or HRA Dependents, the balance of such Retiree HRA is forfeited. A Retired HRA Participant who becomes a Medicare Connector Participant with a Medicare Connector HRA pursuant to the elections of his or her Plan Sponsor shall continue to be considered a Retired HRA Participant under this Article IX and shall remain eligible for reimbursement from his or her Retiree HRA. The HRA Participant may seek reimbursement from his or her Retiree HRA and Medicare Connector HRA in the order and manner

established by the Administrator from time to time, in coordination with the HRA Claims Administrator and Medicare Connector HRA Claims Administrator. Similarly, Spouses and other HRA Dependents of Retired HRA Participants who become Medicare Connector Dependents may continue to benefit from a Retiree HRA where applicable.

(g) ***Reimbursement Procedure.***

(i) *Timing.* Within 30 days after receipt by the HRA Claims Administrator of a reimbursement Claim from an HRA Participant, the HRA Claims Administrator will reimburse the HRA Participant for the HRA Participant's Eligible Medical Care Expenses or the HRA Claims Administrator will notify the HRA Participant that the Claim has been denied (*see Section 9.07* regarding procedures for claim denials and appeals). This time period may be extended for an additional 15 days for matters beyond the control of the HRA Claims Administrator, including in cases where a reimbursement claim is incomplete. The HRA Claims Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the HRA Participant 45 days in which to complete an incomplete claim for reimbursement.

(ii) *Claims Substantiation.* An HRA Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the HRA Claims Administrator in such form as the HRA Claims Administrator may prescribe, by no later than the April 30 following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

(A) the person or persons on whose behalf Medical Care Expenses have been incurred;
(B) the nature and date of the Medical Care Expenses so incurred;
(C) the amount of the requested reimbursement; and
(D) a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted.

The claims application shall be accompanied by bills, invoices, explanations of benefits, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the HRA Claims Administrator may reasonably request.

The HRA Claims Administrator may also electronically verify the eligibility of Medical Care Expenses through the use of a "Benefits Card," e.g., an electronic health care debit card pursuant to IRS guidance for such transactions.

(iii) *Claims Denied.* Claims for reimbursement that are denied are subject to the appeals procedure in Section 9.07.

(h) ***Reimbursements After Becoming a Terminated Participant; Continuation Coverage.*** When an HRA Participant becomes a Terminated Participant under Section 2.84, such Participant (or the Participant's estate) may claim reimbursement for any Eligible Medical Care Expenses incurred during the Period of Coverage, provided that the Participant (or the Participant's estate) files a claim within 90 days following the effective date of termination. Thereafter, if any balance remains in the HRA, such balances shall be forfeited.

Notwithstanding any provision to the contrary in this Plan, to the extent required by Continuation Coverage, the HRA Participant and his or her Spouse and HRA Dependents (Continuation Beneficiaries), whose coverage terminates under the Plan because of a qualifying event, shall be given the opportunity to continue the same coverage that he or she had under the Plan the day before the qualifying event for the periods prescribed by the Plan's Continuation Coverage policies.

At the beginning of the Plan Year, Continuation Beneficiaries shall not be credited with the annual contribution amount that is made available to other HRA Participants; however, any unused reimbursement amounts from the previous Coverage Period shall be carried over (provided that the applicable Continuation Coverage premium is paid).

(i) ***Opt Out.*** In accordance with IRS *Notice 2013-54*, a Terminated Participant as described in Section 2.90, an HRA Participant who otherwise incurs a Termination of Employment may opt out of the HRA at the time of Termination, or at other times permitted by the Plan, pursuant to an HRA opt-out policy established by the General Board that complies with *Notice 2013-54* and the PPACA. Similarly, a Retired HRA Participant may opt out of the HRA at the time of Retirement, or at other times permitted by the Plan, pursuant to an HRA opt-out policy established by the General Board that complies with *Notice 2013-54* and the PPACA.

(j) ***Named Fiduciary; Compliance with Applicable Law.***

(i) *Named Fiduciary.* The General Board is the named fiduciary for the HRA.

(ii) *Laws Applicable to Group Health Plans.* HRA Benefits shall be provided in compliance with HIPAA, the Code, the PPACA and HCERA, FMLA, USERRA, and other group health plan laws to the extent applicable and required by such laws.

(k) ***Coordination of Benefits; Health FSA to Reimburse First.*** HRA Benefits under the HRA are intended to pay benefits solely for Eligible Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from the HRA. Without limiting the foregoing, if the Participant's Eligible Medical Care Expenses are covered by both this HRA and by the Health FSA (if the Participant has elected the Health FSA), then the HRA is not available for reimbursement of such Eligible Medical Care Expenses until after amounts available for reimbursement under the Health FSA are exhausted first.

9.07 Appeals Procedure. If a Claim for reimbursement under the HRA is wholly or partially denied, claims shall be administered in accordance with the claims and appeals procedure set forth in Section 14.06. The General Board is responsible for appeals; however, the General Board may, in its discretion, assign the duties to hear and decide appeals to the HRA Claims Administrator or other entity of its choice.

9.08 Recordkeeping and Administration.

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

(b) ***Powers of the Administrator.*** The General Board shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the HRA and this Article IX and to decide all matters thereunder, and all determinations of the General Board with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the General Board shall have the following discretionary authority:

(i) to construe and interpret this Article IX, including all possible ambiguities, inconsistencies and omissions in the Article and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of HRA Benefits under this Article;

(ii) to prescribe procedures to be followed and the Forms to be used by Employees and HRA Participants to enroll and submit Claims pursuant to this Article IX;

(iii) to prepare and distribute information explaining this Article IX, the HRA and the HRA Benefits hereunder in such manner as the General Board determines to be appropriate;

(iv) to request and receive from all Employees, HRA Participants, and Plan Sponsors such information as the General Board shall from time to time determine to be necessary for the proper administration of the HRA;

(v) to furnish each Employee and HRA Participant with such reports with respect to the administration of the HRA as the General Board determines to be reasonable and appropriate;

(vi) to receive, review and keep on file such reports and information concerning the HRA Benefits covered by the HRA as the General Board determines from time to time to be necessary and proper;

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

(viii) to sign documents for the purpose of administering the HRA, or to designate an individual or individuals to sign documents for the purpose of administering the HRA;

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

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

(c) ***Reliance on Participant, Experts, etc.*** The General Board may rely upon the information submitted by an HRA Participant as being proper under the HRA and shall not be responsible for any act or failure to act because of a direction or lack of direction by an HRA Participant. The General Board will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys or other experts employed or engaged by the General Board.

(d) ***Provision for Third-Party Plan Service Providers.*** The General Board may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the HRA. Unless otherwise provided in the service agreement, obligations under this Article shall remain the obligations of the General Board, Plan Sponsor or Plan.

(e) ***Exclusion of Liability.*** To the extent permitted by law, the General Board shall not incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of this Article IX.

(f) ***Effect of Mistake.*** In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any HRA Participant, or the amount of HRA Benefits paid or to be paid to an HRA Participant or other person, the General Board shall cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as are necessary in its judgment to correct such HRA, to the extent that it deems administratively possible and otherwise permissible under Code §105, the Treasury Regulations issued thereunder and other applicable law.

9.09 General Provisions

(a) ***Code Compliance.*** It is intended that this HRA meet all applicable requirements of the Code, PPACA, all Treasury Regulations issued thereunder and any other applicable IRS guidance. This HRA shall be construed, operated and administered accordingly. In the event of any conflict between any part, clause or provision of this Article IX and the Code or PPACA, the provisions of the Code and PPACA shall be deemed controlling, and any conflicting part, clause or provision of this Article shall be deemed superseded to the extent of the conflict.

(b) ***No Guarantee of Tax Consequences.*** Although the HRA is designed to comply with Code §105 and §106 and *IRS Notice 2002-45* and be a tax-exempt employer-provided health benefit, neither the General Board nor any Plan Sponsor makes any commitment or guarantee that any amounts paid to or for the benefit of an HRA Participant under this HRA will be excludable from the HRA Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each HRA Participant to determine whether each payment under the HRA is excludable from the HRA Participant's gross income for federal, state and local income tax purposes, and to notify the General Board if the HRA Participant has any reason to believe that such payment is not so excludable.

(c) ***Indemnification of Employer.*** If any HRA Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and such payments do not qualify for such treatment under the Code, such HRA Participant shall indemnify and reimburse the General Board or Plan Sponsor for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Article X – Medicare Connector Program

10.01 In General. The Medicare Connector Program ("Medicare Connector") is intended to permit an eligible Medicare Connector Participant (as described in Section 10.04 below) of a Medicare Connector Plan Sponsor (defined below) to choose from an array of Medicare Supplement Plans through a connector or exchange. The Medicare Connector Program also allows Medicare Connector Plan Sponsors to provide financial assistance through Medicare Connector HRAs (described below) to their Medicare Connector Participants for the purchase (payment) of: retiree health plan premiums, premiums for individual Medicare Supplement Plans and out-of-pocket medical expenses.. Capitalized terms used in this Article X that are not otherwise defined in the Plan shall have the meanings set forth in Section 10.03.

10.02 Legal Status. The Medicare Connector Program functions as a private exchange for retired Employees and other Medicare-eligible individuals associated with a Medicare Connector Plan Sponsor, through which such individuals can purchase individual Medicare Supplement Plans. The Medicare Connector HRA is intended to qualify as an employer-provided medical reimbursement plan under Code §§ 105 and 106 and the Treasury Regulations issued thereunder, and as a health reimbursement arrangement as defined under *IRS Notice 2002-45*, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Medicare Connector HRA are intended to be eligible for exclusion from Medicare Connector HRA Participants' gross income under Code §105(b).

10.03 Definitions.

(a) "Benefits" means the reimbursement benefits for Medical Care Expenses described under Section 10.05.

(b) "Effective Date" of this Article X and the Medicare Connector Program is January 1, 2012.

(c) "Employee" means Employee as defined in Section 2.35 of the Plan.

(d) "Employer" for the purposes of the Medicare Connector HRA and this Article X means a Medicare Connector Participant's Plan Sponsor.

(e) "Health FSA" means the health flexible spending arrangement (account) as defined in Proposed Treasury Regulation §1.125-2, Q/A-7(a), called the Medical Reimbursement Program (or Medical Reimbursement Account or MRA) and described in Article VII.

(f) "HRA" means a health reimbursement arrangement (account) as defined in *IRS Notice 2002-45* and described in Sections 2.50 and 9.05 of the Plan. HRA includes a Retiree HRA as defined in Section 9.03(t) of the Plan, but specifically excludes a Medicare Connector HRA.

(g) "Medical Care Expenses" has the meaning defined in Section 10.06(b)(i).

(h) "Medicare Connector Administrator" means the third-party administrator, i.e., the connector or exchange operator, chosen and engaged by the General Board. The General Board may change the Medicare Connector Administrator at any time without notice to Participants.

(i) "Medicare Connector Dependent" means any individual who qualifies as an eligible dependent of a Medicare Connector Participant and who is eligible to participate in the Medicare Connector Program under the rules and policies of the Plan Sponsor. A Medicare Connector Dependent may also be a Medicare Connector HRA Dependent if he or she satisfies the eligibility rules of his or her Plan Sponsor.

(j) "Medicare Connector HRA" means a health reimbursement arrangement (account) as defined in *IRS Notice 2002-45* and described in Section 10.05(b) and 10.06 of the Plan.

(k) "Medicare Connector HRA Claims Administrator" means the third-party claims processing administrator chosen and engaged by the General Board, which is OneExchange (formerly known as Extend Health) as of January 1, 2012. The General Board may change the Medicare Connector HRA Claims Administrator at any time without notice to Participants.

(l) "Medicare Connector HRA Dependent" means any individual who qualifies as an eligible dependent of a Medicare Connector HRA Participant and who is eligible to participate in the Medicare Connector HRA under the rules and policies of the Plan Sponsor. The Medicare Connector HRA does not cover Medical Care Expenses of dependents defined in Code §152 who are not covered under the Medicare Connector Program.

(m) "Medicare Connector HRA Participant" means a person who is an Employee or former Employee who is eligible to participate in the Medicare Connector Program and a Medicare Connector HRA in accordance with the provisions of this Article X.

(n) "Medicare Connector Participant" means an individual, typically a retired Employee or disabled former Employee, who is eligible to participate in the Medicare Connector Program in accordance with the provisions of this Article X.

(o) "Medicare Connector Program" means the private Medicare Supplement Plan exchange described in this Article X.

(p) "Medicare Supplement Plan" means an individual plan of insurance designed to supplement and complement traditional Medicare Parts A and B, such as a Medigap

plan, a Medicare Part D prescription drug plan or other Medicare supplement insurance policy; or to replace traditional Medicare, such as a Medicare Advantage Plan (Part C Medicare PPO or HMO). Medicare Supplement Plans also include vision, dental and mental health insurance plans designed to supplement Medicare Parts A and B.

(q) "Period of Coverage" means the Plan Year, generally, and may mean the period from the date of enrollment in the Medicare Connector Program to the end of the then-current Plan Year for a Medicare Connector Participant who becomes eligible during a Plan Year.

(r) "Plan Sponsor" means, for the purposes of the Medicare Connector Program under this Article X, an entity specified in Section 1.07 of the Plan that has executed an Adoption Agreement with respect to those of its Employees who are permitted to be covered under Section 1.06(b), as specified by type or class of Employee in the Adoption Agreement. A Plan Sponsor for the Medicare Connector Program need not be a Plan Sponsor for other components of the Plan; however, if the entity is a Plan Sponsor solely for the Medicare Connector Program, the provisions of Articles XII, XIV, XV and XVI of the Plan shall still apply.

(s) "Spouse" means an individual who is legally married to a Medicare Connector HRA Participant as determined under applicable state law (and who is treated as a spouse under the Code or is otherwise permitted to be covered in a HRA under *IRS Notice 2002-45* and other IRS guidance). To be eligible under the HRA for claims reimbursement, the Medicare Connector HRA Participant's Spouse must also be covered under the Medicare Connector Program.

10.04 Eligibility to Participate. An individual is eligible to participate in the Medicare Connector Program if his or her Plan Sponsor has elected to sponsor the Medicare Connector Program through an Adoption Agreement, and he or she has satisfied the eligibility requirements to become a Medicare Connector Participant or Medicare Connector Dependent established by his or her Plan Sponsor in its own policies and rules and as indicated in its Adoption Agreement. Once the General Board and the Medicare Connector Claims Administrator have determined that a retired Employee or other individual has met the Medicare Connector Program's eligibility requirements, and the Employee has enrolled pursuant to Section 10.04 below, the Employee's coverage in the Medicare Connector Program will commence.

(a) ***Medicare Parts A and B.*** Notwithstanding anything else to the contrary, to become a Medicare Connector Participant an individual must be eligible for and enrolled in Medicare Part A (hospitalization) and Medicare Part B (physician fees and eligible medical services).

(b) ***Retired Employees.*** Retired Employees who are eligible for Medicare and satisfy the eligibility rules to become Medicare Connector Participants established by their Plan

Sponsor and elected on its Adoption Agreement are eligible to participate in the Medicare Connector Program.

(c) ***Disabled Former Employees.*** Employees who are Disabled (as defined in Section 2.31 of the Plan) and eligible for Medicare and who satisfy the eligibility rules of the Plan Sponsor are eligible to participate in the Medicare Connector Program. If a Medicare Supplement Plan is not available in a State for a Disabled Participant through the Medicare Connector Administrator, the individual may continue to be covered in a Benefit Option for Active Employees, pursuant to the Plan Sponsor's eligibility rules and the other terms and conditions of the Plan, if the Disabled Participant's Plan Sponsor is a Plan Sponsor for more than solely the Medicare Connector Program.

(d) ***Individuals Who Have Opted-Out of Social Security.*** Individuals who have opted out of Social Security under Code Section 1402(e), or who have accumulated too few credited quarters under Social Security, and are ineligible for Medicare, may be able to become Medicare Connector Participants if they electively enroll in Medicare Parts A and B and pay the required premiums for both programs and otherwise satisfy the eligibility requirements of their Plan Sponsor.

(e) ***Medicare-Eligible Dependents.*** Spouses and other Dependents of Medicare Connector Participants may be eligible for coverage through the Medicare Connector Program, if such Spouses and other Dependents are age 65 and over and eligible for Medicare and if they satisfy the eligibility rules of their Plan Sponsor. Spouses and Dependents of Medicare Connector Participants who are Medicare-eligible due to disability may be eligible for coverage through the Medicare Connector Program, if such disabled Spouses and Dependents satisfy the eligibility rules of the Medicare Connector Participant's Plan Sponsor.

(f) ***Working Aged under Small Employer Exception.*** An actively working Employee of a Medicare Connector Plan Sponsor who is age 65 or older and eligible for Medicare ("Working Aged") may participate in the Medicare Connector Program provided he or she and his or her Employer or Salary-Paying Unit has qualified under the "small employer exception" to the Medicare Secondary Payer Rules [§1862 of the Social Security Act at 42 U.S.C. §1395y(b)(1)(A)(iii)]. Once a Working Aged Employee has been approved by the Centers for Medicare and Medicaid Services for the small employer exception, he or she may become a Medicare Connector Participant, and, to the extent applicable, a Medicare Connector HRA Participant.

(g) ***Medicare Connector HRA Participation.*** A Medicare Connector Participant or Medicare Connector Dependent will be a Medicare Connector HRA Participant or Medicare Connector HRA Dependent, eligible for the Benefits under the Medicare Connector HRA described in Sections 10.05(b) and 10.06, if his or her Plan Sponsor has elected to sponsor a Medicare Connector HRA in its Adoption Agreement, and if he or she

satisfies the eligibility criteria established by his or her Plan Sponsor for contributions to the Medicare Connector HRA. Such contributions, if the Plan Sponsor provides them, are typically based upon years of employment or service with the Plan Sponsor and other rules and requirements established by the Plan Sponsor.

(h) ***Termination of Medicare Connector Participation*.** A Medicare Connector Participant will cease to be a Medicare Connector Participant upon the earliest of:

(i) the termination of the Plan or the Medicare Connector Program;

(ii) the date on which the Medicare Connector Participant's Plan Sponsor ceases to sponsor the Medicare Connector Program;

(iii) the date on which the Medicare Connector Participant elects to discontinue participation in the Medicare Connector Program;

(iv) the date on which a Medicare Connector Participant returns to active employment [other than cases in which he or she qualifies under the small employer exception to the Medicare Secondary Payer Rules as described in Section 10.04(f)] with his or her Plan Sponsor, Employer or Salary-Paying Unit; or

(v) the date on which the Medicare Connector Participant fails to pay the applicable premium for coverage under the Medicare Supplement Plan he or she chose through the Medicare Connector Program.

(i) ***Termination of Medicare Connector HRA Participation*.** A Medicare Connector HRA Participant will cease to be a Medicare Connector HRA Participant upon the earliest of:

(i) the termination of the Plan, the Medicare Connector Program or the Medicare Connector HRA;

(ii) the date on which the Medicare Connector Participant's Plan Sponsor ceases to sponsor the Medicare Connector Program or the Medicare Connector HRA; or

(v) the date on which the Medicare Connector HRA Participant's Medicare Connector HRA balance becomes zero ($0) as a result of forfeiture.

(j) ***Open Enrollment.*** The Administrator and Medicare Connector Administrator may establish limited enrollment periods each year ("Open Enrollment"). Open Enrollment periods will generally coincide with Participants' Changes in Status, e.g., retirement, termination of employment, disability, etc., and with Medicare's open enrollment periods.

(k) ***Effective date of Participation*.** An Employee who first becomes eligible to participate in the Medicare Connector Program may commence participation and become covered on the first day after the eligibility requirements have been satisfied. Once enrolled during the Open Enrollment Period, the Employee's participation will continue year-to-year until the Employee's participation ceases pursuant to Section 10.04(h).

(l) ***Premium Payment*.** Once a Medicare Connector Participant enrolls in a Medicare Supplement Plan through the Medicare Connector Administrator, he or she will pay premiums for coverage directly to the Medicare Supplement insurer or carrier. He or she will not pay his or her Plan Sponsor or pay the General Board through deductions from his or her retirement benefit payments. Medicare Connector Participants are expected to pay such premiums in a timely manner, and may request reimbursement from the Medicare Connector HRA if they are Medicare Connector HRA Participants with available funds in their Medicare Connector HRA.

10.05 Benefits.

(a) ***Medicare Connector Benefits*.** Health coverage and accident and health benefits for Medicare Connector Participants are not provided directly from the Plan. Instead, coverage and health benefits are provided under the terms of the Medicare Supplement Plan that the Medicare Connector Participant chooses through the Medicare Connector Administrator. Claims for health benefits by Medicare Connector Participants, other than specifically provided under the Medicare Connector HRA as described in Section 10.05(b) will not be paid by the Plan.

(b) ***Medicare Connector HRA Benefits*.** The Medicare Connector HRA will reimburse Medicare Connector HRA Participants for Eligible Medical Care Expenses described in this Section 10.05(b) up to the amount in the Medicare Connector Participant's Medicare Connector HRA, as set forth and adjusted under Section 10.05(b)(iv).

(i) Eligible Medical Care Expenses. Under the Medicare Connector HRA, a Medicare Connector HRA Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage.

(A) Incurred. An Eligible Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before an individual becomes a Medicare Connector HRA Participant are not Eligible Medical Care Expenses.

(B) Eligible Medical Care Expenses Generally. "Eligible Medical Care Expenses" means expenses incurred by a Medicare Connector HRA

Participant for medical care, as defined in Code §213 (including, for example, amounts for certain hospital bills, doctor and dental bills, and prescription drugs) including health insurance premiums for individual health insurance policies, Medicare Supplement Plans, dental and vision insurance policies, long-term care insurance policies, and Medicare Part B.

(C) Eligible Medical Care Expenses Exclusions. "Eligible Medical Care Expenses" shall not include the expenses listed as exclusions under Section 10.05(b)(ii).

(D) Expenses Cannot Be Reimbursed or Reimbursable from Another Source. Eligible Medical Care Expenses can only be reimbursed to the extent that the Medicare Connector HRA Participant or other eligible person incurring the Eligible Medical Care Expense is not reimbursed for the expense (or the expense is not reimbursable) through insurance or an accident or health plan. Notwithstanding the preceding sentence, if the "other health plan" is the Health FSA for a Working Aged Medicare Connector Participant described in Section 10.04(f), then Section 10.06(e) shall govern the reimbursement. If only a portion of an Eligible Medical Care Expense has been reimbursed elsewhere (e.g., because the insurance or accident or health plan imposes co-payment, coinsurance or deductible limitations), the Medicare Connector HRA can reimburse the remaining portion of such Eligible Medical Care Expense if it otherwise meets the requirements of this Section 10.05(b).

(ii) Exclusions—Medical Care Expenses That Are Not Reimbursable. Certain expenses are not reimbursable under the HRA, even if they meet the definition of "medical care" under Code §213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs. Any item that does not constitute "medical care" as defined under Code §213 is not reimbursable, including, for example:

(A) Premiums under any employer-sponsored group health plan during active employment.

(B) Continuation coverage premiums.

(C) Premiums for disability insurance.

(D) Long-term care services.

(E) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting

from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

(F) Over-the-counter, non-prescription drugs and medicines for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless they are prescribed by a licensed health care provider.

(G) The salary expense of a nurse to care for a healthy newborn at home.

(H) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.

(I) Funeral and burial expenses.

(J) Household and domestic help (even though recommended by a qualified physician due to an individual's inability to perform physical housework).

(K) Massage therapy (unless prescribed by a doctor to treat a medical condition).

(L) Home or automobile improvements.

(M) Custodial care.

(N) Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.

(O) Social activities, such as dance lessons (even though recommended by a physician for general health improvement).

(P) Bottled water; Maternity clothes; Diaper service or diapers; cosmetics, toiletries, toothpaste, etc.; vitamins and food supplements, unless prescribed by a physician for a specific medical condition; or uniforms or special clothing, such as maternity clothing.

(Q) Automobile insurance premiums.

(R) Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

(iii) Maximum Benefits.

(A) *Maximum Contributions.* The maximum annual dollar amount that may be credited to a Medicare Connector HRA Account for a Medicare Connector HRA Participant for an entire Period of Coverage shall be as determined under the applicable policy established by the Plan Sponsor annually before the beginning of each Plan Year. The applicable policy shall be in writing and uniform and nondiscriminatory among the Plan Sponsor's Medicare Connector HRA Participants.

(B) *Changes.* For each Plan Year, the maximum dollar limit may be changed by the Plan Sponsor and shall be communicated to Medicare Connector HRA Participants and Eligible Employees through an enrollment form, other Open Enrollment materials, or another document.

(iv) Establishment of Account. The General Board or Medicare Connector Claims Administrator will establish and maintain a Medicare Connector HRA with respect to each Medicare Connector HRA Participant but will not create a separate fund or otherwise segregate assets for this purpose. The Medicare Connector HRA so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(A) *Crediting of Accounts.* At the beginning of each Plan Year (or each month, if elected by the Plan Sponsor, the Medicare Connector HRA Participant will receive a contribution, as determined by the Plan Sponsor, to his or her Medicare Connector HRA.

(B) *Debiting of Accounts.* A Medicare Connector HRA Participant's Medicare Connector HRA will be debited during each Period of Coverage for any reimbursement of Eligible Medical Care Expenses incurred during the Period of Coverage.

(C) *Available Amount.* The amount available for reimbursement of Eligible Medical Care Expenses is the amount credited to the Participant's Medicare Connector HRA under Section 10.05(b)(iv)(A) reduced by prior reimbursements debited under Section 10.05(b)(iv)(B).

(v) Carryover of Accounts. If any balance remains in the Medicare Connector HRA Participant's Medicare Connector HRA after all reimbursements have been made for a Period of Coverage, such balance shall be carried over to reimburse the Medicare Connector HRA Participant for Eligible Medical Care Expenses incurred during a subsequent Period of Coverage. There is no limit on amounts which may

be rolled-over from year to year; there also is no maximum limit on an accumulated balance in a Medicare Connector HRA.

10.06 Medicare Connector Health Reimbursement Accounts. A Medicare Connector HRA Participant or Medicare Connector HRA Dependent may be reimbursed from his or her Medicare Connector HRA for Eligible Medical Care Expenses [as described in Section 10.05(b)(i)] until such Medicare Connector HRA is exhausted. HRA balance amounts are carried over from Plan Year to Plan Year as long as the Medicare Connector HRA Participant or Medicare Connector HRA Dependent remains eligible.

(a) ***Death of Medicare Connector HRA Participant or Medicare Connector HRA Dependent.*** Upon the death of a Medicare Connector HRA Participant, contributions to his or her Medicare Connector HRA will cease. If a Plan Sponsor makes contributions to a Medicare Connector HRA for a Spouse or Medicare Connector HRA Dependent, the contributions will cease upon the death of the Spouse or Medicare Connector HRA Dependent.

Upon the death of a Medicare Connector HRA Participant, if such deceased Medicare Connector HRA Participant has an eligible surviving Spouse or eligible surviving Medicare Connector HRA Dependents, the eligible survivors may be reimbursed from the Medicare Connector HRA of the deceased individual for Eligible Medical Care Expenses until such Medicare Connector HRA is exhausted or until such survivors die. If a Medicare Connector HRA Participant dies with a balance in his or her Medicare Connector HRA and has no eligible surviving Spouse or Medicare Connector HRA Dependents, the balance of such Medicare Connector HRA is forfeited to the Plan Sponsor. If a surviving Medicare Connector HRA Dependent dies with a balance in his or her Medicare Connector HRA and there are no other eligible surviving Medicare Connector HRA Dependents associated with the same account, the balance of such Medicare Connector HRA is forfeited to the Plan Sponsor. Unused funds in the Medicare Connector HRA of a deceased individual will be forfeited 365 days after his or her death. During the 365 days, reimbursement for Eligible Medical Care Expenses incurred by the deceased individual prior to his or her death may be made to the decedent’s estate from the Medicare Connector HRA.

(b) ***Divorce.*** If a Medicare Connector HRA Participant divorces, depending upon the eligibility rules of his or her Plan Sponsor, contributions to a Medicare Connector HRA for the former Spouse may terminate.

(c) ***Return to Active Employment.*** If a Medicare Connector HRA Participant returns to active employment or service with a Plan Sponsor (or Salary-Paying Unit) and is no longer eligible for the Medicare Connector Program, unused funds (i.e., the then-current balance) in his or her Medicare Connector HRA will be forfeited 180 days after loss of coverage through the Medicare Connector Program. During that time, the Medicare Connector HRA may make reimbursements for Eligible Medical Care Expenses incurred while the individual was covered through the Medicare Connector Program.

(d) ***Reimbursement Procedure.***

(i) *Timing.* Generally, within 30 days after receipt by the Medicare Connector HRA Claims Administrator of a reimbursement Claim, the Medicare Connector HRA Claims Administrator will reimburse the Medicare Connector HRA Participant or Medicare Connector HRA Dependent for Eligible Medical Care Expenses or the Medicare Connector HRA Claims Administrator will notify the Claimant that the Claim has been denied (*see Section 10.08* regarding procedures for claim denials and appeals procedures). This time period may be extended for an additional 15 days for matters beyond the control of the Medicare Connector HRA Claims Administrator, including in cases where a reimbursement Claim is incomplete. The Medicare Connector HRA Claims Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Claimant 45 days, after notice from the Administrator, in which to complete an incomplete Claim for reimbursement.

(ii) *Claims Substantiation.* A Medicare Connector HRA Participant or Medicare Connector HRA Dependent who seeks Benefits may apply for reimbursement by submitting an application in writing to the Medicare Connector HRA Claims Administrator in such form as the Medicare Connector HRA Claims Administrator may prescribe, by no later than the April 30 following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

(A) the person or persons on whose behalf Medical Care Expenses have been incurred;
(B) the nature and date of the Medical Care Expenses so incurred;
(C) the amount of the requested reimbursement; and
(D) a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any and if applicable, for such Medical Care Expenses has been exhausted.

The application shall be accompanied by bills, invoices, explanations of benefits, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Medicare Connector HRA Claims Administrator may reasonably request.

The Medicare Connector HRA Claims Administrator may also electronically verify the eligibility of Medical Care Expenses through the use of a "Benefits Card," e.g., an electronic debit card pursuant to IRS guidance for such transactions.

(iii) *Claims Denied.* Claims for reimbursement that are denied are subject to the appeals procedure in Section 10.08.

(e) ***Coordination of Benefits; Health FSA to Reimburse First.*** The Medicare Connector HRA is intended to pay benefits solely for Eligible Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from the Medicare Connector HRA. Without limiting the foregoing, if the Medicare Connector Participant's Eligible Medical Care Expenses are covered by both this Medicare Connector HRA and by the Health FSA because he or she is Working Aged and eligible under Section 10.04(f), then the Medicare Connector HRA is not available for reimbursement of such Eligible Medical Care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

In addition, if a Medicare Connector HRA Participant or Medicare Connector HRA Dependent is also a Retired HRA Participant (or Dependent thereof), the individual may choose whether to have a particular Eligible Medical Care Expense reimbursed from the Medicare Connector HRA or the Retiree HRA in accordance with the procedures and rules established by the Administrator and the Medicare Connector HRA Claims Administrator.

(f) ***Opt-Out.*** In accordance with IRS *Notice 2013-54*, a Medicare Connector HRA Participant may opt out of the Medicare Connector HRA at the time of Retirement, or at other times permitted by the Plan. This opt-out opportunity must be offered at least once annually, pursuant to an HRA opt-out policy established by the General Board that complies with *Notice 2013-54* and the PPACA.

10.07 Compliance with Applicable Laws.

(a) ***Named Fiduciary.*** The Plan Sponsor is the named fiduciary for the Medicare Connector HRA.

(b) ***Applicable Law.*** Medicare Connector HRA Benefits shall be provided in compliance with HIPAA, the Code, the Social Security Act, PPACA and HCERA, and other federal laws governing accident and health plans to the extent applicable and required by such laws.

10.08 Appeals Procedure. If a Claim for reimbursement under the Medicare Connector HRA is wholly or partially denied, appeals shall be administered in accordance with the following procedures. The appeals procedures set forth in Section 14.06 shall not apply to Claims under the Medicare Connector HRA. The Plan Sponsor, in adopting the Medicare Connector Program, agrees to be responsible for appeals of Claims under the Medicare Connector HRA.

If a Claimant is denied benefits or eligibility hereunder, the Claimant shall have the right to appeal the decision in accordance with the following procedures:

(a) ***Appeal Procedure.*** The Plan Sponsor shall establish an appeals procedure containing no more than a two-level process.

(b) ***Procedure Published.*** The established appeal procedure shall be published for Medicare Connector HRA Participants and Medicare Connector HRA Dependents.

(c) ***Plan Sponsor Decision Final.*** The Plan Sponsor's decision, with respect to appeals that it is authorized to hear and decide, shall be final and not subject to action of the Administrator or Medicare Connector HRA Claims Administrator.

(d) ***PPACA.*** To the extent they may be applicable, the Plan Sponsor's appeals procedures hereunder shall incorporate the appeals procedures set forth in the PPACA and the regulations promulgated thereunder.

(e) ***Evidence.*** The Claimant or his or her duly authorized representative may submit evidence to the Plan Sponsor with respect to the Claim, subject to conditions and time limitations set by the Plan Sponsor, but the expenses related to such submission will not be borne by the Plan Sponsor, General Board, or Plan.

(f) ***Notice.*** The Plan Sponsor, or its agent, shall provide written Notice of the decision resulting from an appeal to the Claimant. Such Notice shall include specific reasons for the decision, written in a manner calculated to be understood by the Claimant, and such Notice shall be mailed to the Claimant by the Plan Sponsor or its agent within a reasonable time following the action by the Plan Sponsor.

(g) ***Appeal a Condition Precedent to Civil Action.*** No cause of action in civil law with respect to any alleged violation of the terms and conditions of the Medicare Connector Program or the Medicare Connector HRA or any contract hereunder shall be commenced or maintained by any Claimant in state or federal court unless and until such Claimant shall have initiated and completed the process of an appeal as set forth in this Section 10.08.

10.09 Administration.

(a) ***Administrator.*** The administration of the Medicare Connector HRA shall be under the supervision of the General Board. It is the principal duty of the General Board to see that this Medicare Connector HRA is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Medicare Connector HRA without discrimination among them.

(b) ***Powers of the Administrator.*** The General Board shall have such duties and powers as it considers necessary or appropriate to discharge this Article X. It shall have the exclusive right to interpret the Medicare Connector HRA, other than appeals determinations as described in Section 10.08 and this Article X, and to decide all matters thereunder. All determinations of the General Board with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the General Board shall have the following discretionary authority to:

(i) construe and interpret this Article X, including all possible ambiguities, inconsistencies and omissions in the Article and related documents, and to decide all questions of fact, questions relating to eligibility (with the cooperation of the Plan Sponsor), and participation, and questions of Medicare Connector HRA Benefits under this Article;

(ii) prescribe procedures to be followed and the Forms to be used by Employees and Medicare Connector HRA Participants to enroll and submit Claims pursuant to this Article X;

(iii) prepare and distribute information explaining this Article X, the Medicare Connector HRA and the Medicare Connector HRA Benefits hereunder in such manner as the General Board determines to be appropriate;

(iv) request and receive from all Employees, Medicare Connector HRA Participants and Plan Sponsors such information as the General Board shall from time to time determine to be necessary for the proper administration of the Medicare Connector HRA;

(v) furnish each Employee and Medicare Connector HRA Participant with such reports with respect to the administration of the Medicare Connector HRA as the General Board determines to be reasonable and appropriate;

(vi) receive, review and keep on file such reports and information concerning the Medicare Connector HRA Benefits covered by the Medicare Connector HRA as the General Board determines from time to time to be necessary and proper;

(vii) appoint and employ such individuals or entities to assist in the administration of the Medicare Connector HRA as the General Board determines to be necessary or advisable, including legal counsel and benefit consultants;

(viii) sign documents for the purpose of administering the Medicare Connector HRA, or to designate an individual or individuals to sign documents for the purpose of administering the Medicare Connector HRA;

(ix) secure independent medical or other advice and require such evidence as it deems necessary to assist a Plan Sponsor in deciding any claim or appeal; and

(x) maintain the books of accounts, records, and other data in the manner necessary for proper administration of the Medicare Connector HRA, and to meet any applicable disclosure and reporting requirements.

(c) ***Reliance on Participant, Experts, etc.*** The General Board and Plan Sponsor may rely upon the information submitted by a Medicare Connector HRA Participant as being proper under the Medicare Connector HRA and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Medicare Connector HRA Participant. The General Board and Plan Sponsor will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the General Board or Plan Sponsor.

(d) ***Provision for Third-Party Plan Service Providers.*** The General Board and Plan Sponsor may employ the services of such persons as they may deem necessary or desirable in connection with the operation of the Medicare Connector HRA. Unless otherwise provided in the service agreement, obligations under this Article shall remain the obligations of the General Board, Plan Sponsor or Plan.

(e) ***Exclusion of Liability.*** To the extent permitted by law, the General Board or Plan Sponsor shall not incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of this Article X.

(f) ***Effect of Mistake.*** In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Medicare Connector HRA Participant, or the amount of Medicare Connector HRA Benefits paid or to be paid to a Medicare Connector HRA Participant or other person, the General Board or Plan Sponsor shall cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as are necessary in its judgment to correct such Medicare Connector HRA to the extent that it deems administratively possible and otherwise permissible under Code §105, the Treasury Regulations issued thereunder and other applicable law.

10.10 General Provisions.

(a) ***Code Compliance.*** It is intended that the Medicare Connector HRA meets all applicable requirements of the Code and requirements of all Treasury Regulations issued thereunder and any other applicable IRS guidance including guidance implementing the PPACA that may apply to the Plan. This Medicare Connector HRA shall be construed, operated and administered accordingly. In the event of any conflict between any part, clause or provision of this Article X and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Article X shall be deemed superseded to the extent of the conflict.

(b) ***No Guarantee of Tax Consequences.*** Although the Medicare Connector HRA is designed to comply with Code §105 and §106 and *IRS Notice 2002-45* and be a tax-exempt employer-provided health benefit, neither the General Board nor any Plan Sponsor makes any commitment or guarantee that any amounts paid to or for the benefit of a Medicare Connector HRA Participant under this Medicare Connector HRA will be excludable from the Medicare Connector HRA Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Medicare Connector HRA Participant to determine whether each payment under the Medicare Connector HRA is excludable from his or her gross income for federal, state or local income tax purposes, and to notify the General Board or Plan Sponsor if he or she has any reason to believe that such payment is not so excludable.

(c) ***Indemnification of Plan Sponsor.*** If any Medicare Connector HRA Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Medicare Connector HRA Participant shall indemnify and reimburse the Administrator, Plan, Plan Sponsor and/or his or her Employer or Salary-Paying Unit for any liability they may incur for failure to withhold federal income taxes, Social Security taxes or other taxes from such payments or reimbursements.

Article XI — Nondiscrimination

11.01 Reduction of Contributions and Benefits. The Plan Administrator may reject any election and reduce the amount of Contributions or nontaxable benefits to the extent the Plan Administrator deems necessary to assure that the Plan does not discriminate in violation of Code §125 or any other applicable provision of law, or to prevent taxation of key employees under the provisions of Code §125(b)(2). Any rejection of elections or any reduction of Contributions or benefits shall be made by the Plan Administrator on a reasonable and nondiscriminatory basis. Contributions that may not be paid out because of benefit reductions imposed by this Section 11.01 shall be forfeited.

11.02 Prohibition of Discrimination. Any discretionary acts to be taken under the terms and provisions of this Plan by the Plan Administrator or by the applicable Plan Sponsor shall be uniform in their nature and application; no discretionary acts shall be taken that would be discriminatory under the provisions of the Code relating to the Plan as such provisions now exist or may from time to time be amended.

Article XII — Use and Disclosure of Protected Health Information

12.01 Definitions. For purposes of this Article XII, the following special definitions shall apply whenever such word or phrase is capitalized and used herein:

(a) "Health Plan" shall have the same meaning as the term "health plan" in 45 CFR §160.103.

(b) "Plan Administrative Functions" shall have the same meaning as the term "plan administrative functions" in 45 CFR §164.504(a).

(c) "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 42 CFR §164.501.

(d) "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or his or her designee.

(e) "Summary Health Information" shall have the same meaning as the term "summary health information" in 45 CFR §164.504(a).

12.02 Permitted Uses and Disclosure of Summary Health Information. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the General Board in its role as a Plan Sponsor, or to any other Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of:

(a) Obtaining premium bids from Health Plans for providing health insurance coverage under the Plan; or

(b) Modifying, amending or terminating its participation in the Plan.

12.03 Permitted Disclosure of Enrollment Information. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to a Plan Sponsor 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.

12.04 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Functions. Unless otherwise prohibited by law, and subject to the conditions described in Section 10.05 and obtaining written certification pursuant to Section 10.07, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose PHI to a Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI only to carry out Plan Administrative Functions for the Plan. Notwithstanding the provisions of the Plan to the contrary, in no event shall the General Board be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

12.05 Conditions of Disclosure for Plan Administrative Functions. Each Plan Sponsor agrees that with respect to PHI disclosed to it by the Plan or a health insurance issuer or HMO with respect to the Plan (other than enrollment information and Summary Health Information, which are not subject to the restrictions of Section 10.05), the Plan Sponsor shall:

(a) not use or disclose the PHI other than as permitted or required by the Plan or as required by law;

(b) ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(c) not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(d) report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for herein of which the Plan Sponsor is aware;

(e) make available PHI in accordance with 45 CFR §164.524; make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526; and make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

(f) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary upon request for purposes of determining compliance by the Plans with subpart E of 45 CFR §164;

(g) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made—except that if such return or destruction is not feasible, Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information impossible; and

(h) ensure that there is adequate separation between the Plan and Plan Sponsor in accordance with 45 CFR §504(f)(2)(iii) and Section 10.06.

12.06 Adequate Separation. The General Board shall allow access to PHI (including PHI received from a health insurance issuer or HMO with respect to the Plan) to the employees, classes of employees or other work force members in certain departments or functions, who are under the control of and specified by the General Board. The General Board shall only permit disclosures to employees, classes of employees or other work force members under the control of the General Board who shall have access to PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The permitted employees, classes of employees or other workforce members shall only have access to and use PHI to the extent necessary to perform the Plan Administrative Functions that the General Board provides for the Plans. In the event that any of the specified employees, classes of employees or other workforce members do not comply with the provisions of this Article XII, that employee or other workforce member shall be subject to disciplinary action and sanctions by the General Board for non-

compliance pursuant to the General Board's disciplinary and termination policies and procedures.

12.07 Certification of General Board. The Plan, or a health insurance issuer or HMO with respect to the Plan, shall disclose PHI to the General Board only upon the receipt of a certification by the General Board that the Plans have been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the General Board agrees to the conditions of disclosure set forth in Section 10.05.

12.08 Restrictions on Disclosure. Notwithstanding the provisions of this Article XII or the Plan to the contrary, neither the Plan, nor a health insurance issuer or HMO with respect to the Plan shall disclose PHI to the General Board:

(a) unless a statement required by 45 CFR §164.520(b)(1)(iii)(C) is included in the appropriate notice; or

(b) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the General Board.

Article XIII — Trustee

13.01 Responsibilities of the Trustee. The Trustee shall have the following categories of responsibilities in addition to those responsibilities set out in Article I and the Trust Agreement:

(a) To invest, manage and control the Plan assets pursuant to the terms of the Trust; and

(b) At the direction of the Plan Administrator, to pay benefits required under the Plan to be paid to or on behalf of Participants and their Dependents.

13.02 Powers of the Trustee. The Trustee, in addition to all powers and authorities under common law, statutory authority and other provisions of the Plan, shall have the following powers and authorities to be exercised in the Trustee's sole discretion to:

(a) Pool all or any of the assets of the Plan, from time to time, with assets belonging to any other employee benefit plan created by a unit of The United Methodist Church or an affiliated unit of The United Methodist Church; The Trustee further shall have discretion to commingle such assets in order to make joint or common investments and carry joint accounts on behalf of this Plan and such other trust or trusts, and shall allocate undivided shares or interests in such investments or accounts or any pooled assets of the two or more trusts in accordance with their respective interests;

(b) Do all such acts and exercise all such rights and privileges, although not specifically mentioned herein, as the Trustee may deem necessary to carry out the purposes of the Plan.

13.04 Funding Through Insurance Contracts. The Trustee may, in lieu of paying benefits to a Participant from assets held by the Trustee, enter into a contract or an agreement with one or more insurance companies for the purchase from such Plan assets of one or more insurance contracts that provide benefits to Participants under the Plan.

13.05 Services. Nothing herein shall prevent the Trustee from contracting for services with another entity including one that is, with the Trustee, part of a controlled group.

Article XIV — Administration of the Plan

14.01 Powers and Duties of the Plan Administrator. The General Board shall have the power to take all actions required to carry out the provisions of the Plan. The General Board has the power and discretion to construe the terms of the Plan and to determine all questions arising with the administration, interpretation and application of the Plan. Any such determination by the General Board will be conclusive and binding upon all persons. The General Board, in addition to all the powers and authorities under common law, statutory authority and other provisions of the Plan, shall further have the following powers and duties, which shall be exercised in the General Board's discretion to:

(a) establish procedures, correct any defect, supply any information or reconcile any inconsistency in such manner and to such extent as may be deemed necessary or advisable to carry out the purpose of the Plan;

(b) determine all questions relating to the eligibility of an Employee to participate or remain a participant hereunder and to receive benefits under the Plan;

(c) file or cause to be filed all such annual reports, returns, schedules, descriptions, financial statements and other statements as may be required by any federal or state statute, agency or authority;

(d) obtain from the Plan Sponsors and Employees such information as shall be necessary to the proper administration of the Plan;

(e) determine the amount, manner and time of payment of benefits hereunder;

(f) contract with such insurance carriers, Claim Administrators or other service providers as may be necessary to provide for benefits;

(g) communicate to any Insurer, Claim Administrator or other contract service provider of benefits under this Plan in writing all information required to carry out the provisions of the Plan;

(h) notify the Participants of the Plan in writing of any amendment or termination of the Plan, or of a change in any benefits available under the Plan;

(i) prescribe such Forms as may be required for Employees to make elections under this Plan;

(j) maintain all necessary records for the administration of the Plan;

(k) assist any Employee in understanding his or her rights, benefits or elections under the Plan;

(l) prepare and distribute information explaining the Plan;

(m) construe and interpret the provisions of the Plan; to decide the validity of any election or designation made under the Plan, and the amount, manner and time of any allocation to

accounts or payment of benefits hereunder; and to make factual determinations necessary or appropriate for such decisions or determinations;

(n) appoint or employ advisors including legal and actuarial counsel (who may also be counsel to the Trustee) to render advice with regard to any responsibility of the General Board under the Plan or to assist in the administration of the Plan;

(o) adopt reasonable procedures for determining whether any order, judgment or decree constitutes a QMCSO or other applicable support order;

(p) settle, compromise or submit to arbitration any claims, debts or damages due or owing to or from the Plan, to commence or defend suits or legal or administrative proceedings, and to represent the Plan in all suits and legal and administrative proceedings, and to comply with judicial and administrative orders, decrees, judgments, summons, subpoenas, levies and other writs or instruments of judicial or administrative process, without regard to their potential vulnerability to challenge on jurisdictional or other legal grounds, all within the sole discretion of the General Board; and

(q) do such other acts as it deems reasonably required to administer the Plan in accordance with its provisions, or as may be provided for or required by law.

14.02 Fiduciary Duties. The General Board shall discharge its duties under the Plan:

(a) for the primary purposes of providing benefits to Participants and their Dependents and beneficiaries, and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with the provisions of *The Book of Discipline*.

14.03 Allocation or Delegation of Duties and Responsibilities. In furtherance of its duties and responsibilities under the Plan, the General Board may (subject always to the requirements of Section 14.02):

(a) employ agents including, but not limited to, Claim Administrators, to carry out non-fiduciary responsibilities;

(b) employ agents including, but not limited to, Claim Administrators, to carry out fiduciary responsibilities; and

(c) consult with counsel who may be of counsel to the General Board.

14.04 Records and Reports. The Plan Administrator shall keep a record of all actions taken and shall keep all other books of account, records and other data that may be necessary for proper administration of the Plan and shall be responsible for supplying all information and reports to appropriate government entities, Participants and others as required by law.

14.05 Duties of the Plan Sponsor. The Plan Sponsor shall assume the following duties with respect to the Plan:

(a) to determine initial eligibility consistent with the terms of the Plan and to enroll Clergy Employees and Lay Employees, as applicable, within 30 days of each Employee satisfying the eligibility requirements of the Plan;

(b) to maintain records of Participants' Compensation, enrollment and elections;

(c) to remit Required Contributions to the Plan Administrator;

(d) to provide the Plan Administrator with Notice of a Participant's Termination of Employment, Termination of Conference Relationship or Change of Status, where the Plan Sponsor is made aware of such Change of Status;

(e) to provide the Plan Administrator with statistical data and other information satisfactory in form and accuracy to the Plan Administrator within a reasonable time after a request by the Administrator and in a manner sufficient to enable the Plan Administrator to discharge its duties under the Plan;

(f) to register with and report to government agencies, as appropriate;

(g) to comply with applicable federal and state laws and regulations including, but not limited to, nondiscrimination requirements;

(h) to properly notify Clergy Employees and Lay Employees of their rights and obligations under the Plan, including giving Notices required under the Plan, HIPAA, PPACA or the Code;

(i) to comply with the terms of HIPAA including, but not limited to, the Privacy Rule and the Security Rule; and

(j) to execute an Adoption Agreement indicating any elections regarding optional Plan provisions and any other information called for by the Adoption Agreement.

The Plan Sponsor may be deemed to satisfy its duties through actions by a Salary-Paying Unit or other entity, but the Plan Sponsor remains responsible for the duties if they are not carried out in a timely fashion.

14.06 Claims and Appeals Procedure. The following claims and appeals procedures are subject to any additional rules or procedures that the Plan Administrator may adopt from time to time that are not inconsistent herewith:

(a) ***Filing of a Claim.*** A Claim for benefits under the Plan must be filed by a Claimant with the Plan Administrator or a Claim Administrator on a Form supplied by the Plan Administrator or Claim Administrator within one (1) year after the later of the date:

(i) the events giving rise to the Claim occurred, or

(ii) the Claimant knew or should have known of the facts or events giving rise to the Claim.

If such claim is not filed within one (1) year as described in Section 14.06(a), the Claimant will be deemed to have waived his or her right to make a Claim or to pursue any other remedy, including filing a lawsuit. Generally, a Notice of the disposition of a Claim will be sent to the Claimant within 45 days after all required Forms and materials related to the Claim have been filed. If special circumstances require an extension of time, a Notice of the extension will be furnished to the Claimant, and a Notice of the disposition of a Claim will be sent within an additional 90 days. In compliance with the PPACA and PHSA, Claimants will be notified of a benefit determination (whether adverse or not) with respect to a Claim involving urgent care as soon as possible, taking into account medical exigencies, but not later than 24 hours after the receipt of the Claim. All Claims and appeals procedures established by the Plan Administrator, its Claim Administrators, Insurers and other agents, will comply with applicable provisions of the PPACA, PHSA and regulations thereunder.

(b) ***Denial of Claim.*** If any Claim for benefits under the Plan is wholly or partially denied, the Plan Administrator or Claim Administrator will send the Claimant a Notice of the denial written in a manner calculated to be understood by the Claimant, generally setting forth the following information:

(i) The specific reasons for such denial;

(ii) Specific reference to pertinent Plan provisions on which the denial is based;

(iii) Description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary; and

(iv) Explanation of the Plan's appeals procedures.

If a Claimant is denied benefits or eligibility hereunder, the Claimant shall have the right to appeal the decision in accordance with the following procedures:

(c) ***Appeal Procedure.*** The General Board shall establish an appeal procedure that complies with applicable sections of the PPACA and PHSA governing appeals of adverse benefits determinations.

(i) This appeal procedure may differ for each of the types of Benefit Options offered hereunder.

(ii) The established appeal procedure shall be published in the description of each of the Benefit Options.

(iii) The General Board may delegate any established appeal procedure to a Claim Administrator, Insurer or other agent through agreement, contract or insurance policy.

(d) ***Final Appeal Procedure.***

(i) Notwithstanding anything in the Plan to the contrary, the General Board may delegate the final appeal procedure and determination, with respect to any Benefit Program or Group Benefit Option under the Plan, through agreement, contract or insurance policy to a Claim Administrator, Insurer or other entity. In the event that the General Board so delegates the final appeal procedure to an agent, neither the Plan Administrator nor the Appeals Committee described in Section 12.06(d)(ii) shall hear or decide appeals related to the Benefit Program or Group Benefit Option for which such final appeal procedure has been so delegated.

If the General Board delegates the final appeal procedure with respect to any Benefit Program or Group Benefit Option under the Plan to a Claim Administrator, Insurer or other agent, the General Board shall publish the final appeal procedure in the description of such Benefit Program or Group Benefit Option. The decision of the Claim Administrator or other agent to whom a final appeal procedure has been delegated, with respect to appeals that it is authorized to hear and decide, shall be final and not subject to action of the General Board. The General Board shall ensure that delegated appeals procedures comply with applicable provisions of the PPACA, PHSA and regulations thereunder regarding appeals or adverse benefits determinations.

(ii) There shall be an Appeals Committee of the General Board elected by the General Board that shall hear and decide appeals of denials only of those Claims for which the Claim and appeal procedures have not been delegated to a Claim Administrator, Insurer or other entity, and only after the General Board's established internal appeal procedure has been exhausted.

(iii) The Appeals Committee's decision, with respect to appeals that it is authorized to hear and decide, shall be final and not subject to action of the Plan Administrator.

(iv) After the initial appeal procedure has been completed, if the Claimant's Claim is still fully or partially denied [other than Claims subject to Section 12.06d(i)], the Claim may be heard by the Appeals Committee. The Claimant must submit the request for review by the Appeals Committee in writing on Forms supplied by the Appeals Committee. The Appeals Committee will review the Claim in accordance with its rules and procedures.

(A) The Claimant, his or her duly authorized representative, or a representative of the Plan Sponsor, may request permission to appear personally or by teleconference or videoconference before the Appeals Committee to present evidence with respect to the Claim, subject to conditions and time limitations set by the Appeals Committee; however, the expense for any such personal appearance will not be borne by the General Board or the Plan.

(B) The Appeals Committee, or its agent, shall provide written Notice of the decision resulting from an appeal to the Claimant. Such Notice shall include specific reasons for the decision, written in a manner calculated to be understood by the Claimant, and such Notice shall be mailed to the Claimant by the Appeals Committee or its agent within a reasonable time following the action by the Appeals Committee.

(e) ***External Review.*** Pursuant to the PPACA and PHSA, after exhausting the applicable appeal procedure, a Claimant may choose to participate in an external review program (External Review). External Review applies only if the adverse benefit determination is based on:

- clinical reasons; or
- any exclusions for experimental or investigational services or unproven services.

External Review is not available if the adverse benefit determination is based on explicit Benefit exclusions or defined Benefit limits.

(f) ***Appeal a Condition Precedent to Civil Action.*** No cause of action in civil law with respect to any alleged violation of the terms and conditions of this Plan or any contract hereunder shall be commenced or maintained by any Participant or other Claimant in state or federal court unless and until such Participant shall have initiated and completed the process of an Appeal as set forth in this Section 14.06.

Article XV — Adoption, Amendment and Termination

15.01 Adoption of Plan. This Plan may be adopted by any Plan Sponsor described in Section 1.08 with the consent of the Plan Administrator.

15.02 Adoption Agreement. Any Plan Sponsor adopting this Plan shall file with the Plan Administrator an Adoption Agreement. The Adoption Agreement for the Plan will be in a form prescribed by the Plan Administrator. An adopting Plan Sponsor must complete an Adoption Agreement which, once completed, must be acceptable to the Plan Administrator. The effective date of the Adoption Agreement cannot be any earlier than the first day of the current Plan Year unless the Administrator approves an earlier date after considering any relevant circumstances.

15.03 Plan Sponsor Termination. A Plan Sponsor's sponsorship of the Plan may be terminated as follows:

(a) Upon written notice to the Plan Administrator 180 days in advance of the date of such termination, a Plan Sponsor may terminate its sponsorship of the Plan as established with the Plan Administrator. In such a case, unless all Plan Sponsors terminate sponsorship of the Plan, the Plan will continue in operation as to all non-terminating Plan Sponsors. As a condition precedent to its right to terminate sponsorship of the Plan, a Plan Sponsor must provide written notice of its intent to its Participants at least 60 days in advance of the proposed date of such termination, and must provide to the Plan Administrator evidence of such written notice to the affected Participants. In its discretion, the General Board may waive the required 180 days' notice that a Plan Sponsor ordinarily must provide in order to terminate sponsorship of the Plan, and may allow the termination to become effective as soon as administratively practicable. The General Board may only waive such notice in circumstances that it reasonably determines would cause significant hardship to the Plan Sponsor if termination were delayed, and such immediate termination would not prejudice the Plan (e.g., financially, contractually, actuarially or otherwise), its remaining Plan Sponsors or Participants. The Plan Sponsor's indemnification obligations under Section 16.17 of the Plan shall survive such termination.

(b) Upon written notice to a Plan Sponsor at least 90 days in advance of the date of such termination, the Plan Administrator may terminate a Plan Sponsor's sponsorship of the Plan for breach of the Plan's provisions. The Plan may terminate a Plan Sponsor's sponsorship of the Plan for late remittance or non-remittance of Required Contributions to the Plan Administrator. The Plan Administrator shall notify the Plan Sponsor of its failure to make Required Contributions on a timely basis in writing, and provide to the Plan Sponsor by certified mail with return receipt requested or by overnight commercial courier service (for next day delivery).. If the Plan Sponsor fails to make the Required Contributions, namely payment in full of all outstanding Required Contributions within 15 calendar days after the mailing of such Notice (where mailing includes placing the Notice with an overnight courier service for delivery), the Plan Sponsor shall cease to be a Plan Sponsor. Sponsorship will terminate effective on the first day of the month following the expiration of such 15-day period. However, if such late payment is the first late payment within the last 12 months, then a grace period shall apply, and the termination of sponsorship will not

be effective at such time, but will instead be effective upon the termination date that would apply to a second such late payment within the last 12 months. If a Plan Sponsor's sponsorship is terminated in accordance with this Section, such Plan Sponsor will not be eligible to re-adopt the Plan through an Adoption Agreement for a period of three (3) years after such termination. The termination of a Plan Sponsor from sponsorship under this Plan will not excuse the Plan Sponsor from making payment in full for all Required Contributions for any period of sponsorship of the Plan. The Plan Administrator may establish a policy for extending credit, creating payment plans and collecting payments to implement or supplement the provisions of this Section, which policy may include late fees, interest accruals, service charges and any other reasonable provisions designed to collect amounts due to the Plan or extend credit to a Plan Sponsor. In the case of a termination under this Section, the Plan Administrator will provide Notice of the termination to affected Participants.

15.04 Amendment of Plan. The General Board may amend prospectively or retroactively any or all provisions of this Plan or the Adoption Agreement at any time by written instrument identified as an amendment of the Plan, effective as of a specified date. The Plan Administrator may amend prospectively or retroactively any and all administrative and non-substantive provisions of an Adoption Agreement.

(a) Subject to the discretion of the Plan Administrator, a Plan Sponsor may amend any elective provisions of its Adoption Agreement at any time, with an effective date no earlier than the effective date of the applicable Adoption Agreement, to any extent that it may deem advisable without the consent of any Participant. However, no such amendment may be retroactive without the consent of the Plan Administrator.

(b) No amendment may, without written consent of the Plan Administrator or Trustee, deprive the Plan Administrator or Trustee, respectively, of any of its exemptions and immunities; nor may such amendment change the duties, responsibilities, rights or privileges of the Plan Administrator or Trustee or the provisions of any contract. If any amendment by the Plan Sponsor affects the rights, duties, responsibilities or obligations of the Plan Administrator or Trustee hereunder, such amendment may be made only with the consent of the Plan Administrator or Trustee.

(c) If the Plan (including the Adoption Agreement) is amended in a manner deemed materially unacceptable to a Plan Sponsor, that Plan Sponsor may terminate its participation in the Plan in accordance with Section 15.03. If the Plan Sponsor gives Notice of such termination within 30 days after it learns of a Plan amendment that it deems materially unacceptable, then either:

(i) the Plan Administrator may withdraw or revise such amendment or re-amend the Plan so that the unacceptable elements of such amendment will not become effective as to such Plan Sponsor, or

(ii) the Plan Sponsor's participation in the Plan may terminate pursuant to Section 13.03.

However, the General Board is authorized to amend any or all provisions of this Plan at any time by such written instrument in order to ensure the Plan complies with any

applicable law or regulation. However, the Plan Sponsor shall not have a right to terminate its participation in the Plan on account of such regulatory amendments.

15.05 Termination of Plan by the General Board. The General Board has the right to terminate the Plan and the Trust at any time by giving 90 days advance written notice to all Plan Sponsors. The disposition of assets remaining in the Plan, if any, after all obligations of the Plan have been satisfied, will be at the discretion of the General Board.

15.06 Preservation of Rights. Termination or amendment of the Plan shall not affect the rights of any Active Employee in his or her Medical Reimbursement Account or Dependent Care Account to the extent that he or she can claim reimbursement for expenses incurred prior to such termination or amendment as the case may be to the extent such amount is payable under the terms of the Plan prior to the effective date of such termination or amendment.

Article XVI — Miscellaneous

16.01 Facility of Payment. If the Plan Administrator deems any person entitled to receive any amount under the provisions of this Plan incapable of receiving or disbursing the same by reason of being a minor, illness or infirmity, mental incompetency, or incapacity of any kind, the Plan Administrator may, in its discretion, take the following actions:

(a) apply such amount directly for the comfort, support and maintenance of such person; and

(b) pay such amount to a legal representative or guardian or any other person selected by the Plan Administrator to disburse the amount for such comfort, support and maintenance, including without limitation any relative who had undertaken, wholly or partially, the expense of such person's comfort, care and maintenance, or any institution in whose care or custody the person entitled to the amount may be. The Plan Administrator may, in its discretion, deposit any amount due to a minor to his or her credit in any savings or commercial bank of the Plan Administrator's choice.

Any payment by the Plan Administrator in accordance with this Facility of Payment section will discharge the Plan Administrator from all further liability to the extent of the payment made.

16.02 Lost Payee. Any amount due and payable to a Participant shall be forfeited if the Plan Administrator after reasonable effort is unable to locate the Participant to whom payment is due. Such forfeited amounts shall become part of the assets of the Plan. The Plan Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

16.03 Funding. The obligations of the Plan Sponsors and Salary-Paying Units under this Plan may be funded through contributions to a trust, but need not be, except to the extent required by law. Nothing contained in the Plan shall give a Participant any right, title or interest in any property of the Plan Sponsors and Salary-Paying Units.

16.04 Titles and Headings. The titles and headings of the Articles and Sections of this instrument are placed herein for convenience of reference only, and in the case of any conflicts, the text of this instrument rather than the titles or headings, shall control.

16.05 Number. Wherever used herein, the singular shall include the plural and the plural shall include the singular, except where the context requires otherwise.

16.06 Applicable Law. The Plan and each of its provisions shall be construed according to, and its and their validity determined by, the laws of the State of Illinois, other than its laws respecting choice of law, to the extent such laws are not pre-empted by any federal law, and in accordance with applicable federal law. The Plan is intended to be:

(a) a cafeteria plan under Code §125(d) containing a medical expense reimbursement plan under Code §105 and a dependent care expense reimbursement plan under Code §129;

(b) an employee welfare benefit plan under ERISA §3(1); and

(c) a Church Plan under Code §414(e) and ERISA §3(33) exempt from Title I of ERISA by ERISA §4(b)(2), and shall be construed accordingly.

In addition, state insurance laws and regulations shall not apply to the Plan to the extent they:

(d) are pre-empted by federal law, including, but not limited to, ERISA, the Code, HIPAA, the Church Plan Parity and Entanglement Prevention Act of 1999 (Public Law No: 106-244), and *State ex rel. Farmer v. Monsanto Company*, 517 S.W.2d 129 (Mo. 1974); and

(e) are made inapplicable by state laws, regulations, or case law that exempt self-insured Church Plans from the applicability of state insurance statutes and regulations.

16.07 Conformance with Applicable Law. The General Board may alter any Group Benefit Option or any portion thereof including, but not limited to, lifetime benefit maximums, deductibles, exclusions and benefits that are offered under a particular Group Benefit Option, in order to conform with the laws and regulations thereto of a particular jurisdiction in which this Plan will operate. In addition, the General Board may alter any Group Benefit Option, Benefit Option or Plan provision, or interpret such to conform and comply with the PPACA, PHSA and any regulations, temporary, proposed, interim final or final, and sub-regulatory guidance issued under these laws by the U.S. Department of Health and Human Services, the Internal Revenue Service, the U.S. Department of Labor and, where applicable, rules and regulations related to these laws issued by the Illinois Department of Insurance or another state agency with appropriate jurisdiction.

16.08 Continuation of Benefits Not Guaranteed. Nothing contained in this Plan, nor in the descriptions of the Group Benefit Options offered hereunder, shall be construed to guarantee the continuation of benefits beyond the current Period of Coverage in which a Participant is participating.

16.09 Pooling of Assets and Claims. The General Board, at its own discretion, may pool the assets and claims of this Plan with the assets and claims of other like welfare benefit programs for health care administered by the General Board in accordance with rules and regulations adopted by the General Board.

16.10 Assignment. Employees and Dependents covered under this Plan may not assign, alienate, anticipate or commute any payments under this Plan (except as specifically provided in this section). Further, except as prescribed by law, payments under this Plan will not be subject to the debts, contracts or engagements of any person, nor to any judicial process to levy upon or attach the same for payment. Participants may, however, with the Plan Administrator's approval, authorize the payment of benefits under this Plan directly to the person or institution on whose charges the Claim is based. The Plan and Plan Administrator will be discharged from all liability to the extent of any such payment.

16.11 Overpayments. If an overpayment has been made under the Plan, the Plan Administrator will have the right to recoup and recover any such overpayment from the person to whom such overpayment was made or from any person who received such overpayment.

16.12 No Guarantee of Employment. Neither the creation of the Plan nor anything contained in the Plan gives any Employee any right to remain in the employ of the Plan Administrator or any Plan Sponsor; or any equity or other interest in the assets, business or affairs of the Plan Administrator or any Plan Sponsor.

16.13 Waiver of Claims. Neither the creation of the Plan nor any modification of the Plan nor the payment of any benefits under the Plan will give any Employee or any other person any legal or equitable right against the Plan Administrator, any Plan Sponsor or any service agent (or any employee of the Plan Administrator, any Plan Sponsor or of any service agent) unless such right is specifically provided for in the Plan.

16.14 Severability. If any provision of this Plan is held to be illegal for any reason, that illegality or invalidity will not affect the remaining provisions of this Plan. In such case, this Plan will be construed and enforced as if the illegal or invalid provision or section were not included in the Plan.

16.15 Workers' Compensation Unaffected. This Plan is not in lieu of and does not affect any requirements for coverage under workers' compensation laws of any state.

16.16 Limitation of Liability. All benefits hereunder, other than benefits under the Medical Reimbursement Account Program and the Dependent Care Account Program, are contingent upon and payable solely from the assets of the Trust, including insurance purchased from the Trust, which derive from such Contributions as are received by the Trustee and the investment results attained by the Trustee. No financial obligations, other than those that can be met by the Contributions actually received and the investment results (reduced by any of the Plan Administrator's and Trustee's administrative expenses and charges against the Trust's assets) will be assumed by the Plan Administrator or the Trustee. The Plan Administrator, Claim Administrator, Recordkeeper, Trustee, their officers, employees, contractors or agents will not be personally responsible or otherwise liable for the payment of any benefits hereunder.

16.17 Indemnification. The Plan Sponsor agrees to indemnify the Plan Administrator against any and all actions, causes of action, claims, demands, damages and liabilities incurred or occasioned by any act or omission of the Plan Administrator undertaken in good faith in administration of the Plan. Each Participant agrees to indemnify the Plan Sponsor and the Plan Administrator against and reimburse the Plan Sponsor and Plan Administrator for any benefit paid or provided erroneously to or on behalf of such Participant or his or her Spouse or Dependents. Each Participant agrees to indemnify the Plan Administrator against any and all actions, causes of action, claims, demands, damages and liabilities incurred or occasioned by any act or omission of the Plan Administrator undertaken in good faith in administration of the Plan.

16.18 Alternative Dispute Resolution. If a dispute arises out of or related to the relationship between any Plan Sponsor and the Plan Administrator or Trustee that is not resolved by the parties themselves, the parties agree first to try in good faith to settle the dispute by mediation through the American Arbitration Association, or another mediation or arbitration service mutually agreed upon by the parties, before resorting to arbitration. Thereafter, any remaining unresolved controversy or claim arising out of or relating to the relationship between the Plan Sponsor and the Plan Administrator or Trustee will be settled

by binding arbitration through the American Arbitration Association, or the other mediation or arbitration service mutually agreed upon by the parties.

(a) The site of the mediation or arbitration will be in a city mutually agreed upon by the parties.

(b) The laws of the State of Illinois will apply in situations where federal law is not applicable. The applicable rules of the selected arbitration service will apply. If the service allows the parties to choose the number of arbitrators, unless another number is mutually agreed to, any arbitration hereunder will be before three arbitrators. The award of the arbitrators, or a majority of them, will be final. Judgment upon the award rendered may be entered in any court, state or federal, having jurisdiction.

(c) The fees and costs for mediation will be borne equally by the parties. The fees and costs of arbitration will be allocated to the parties by the arbitrators.

16.19 Participant and Beneficiary Duties. Each person entitled to benefits under the Plan must file with the Plan Administrator and Plan Sponsor from time to time such person's post office address and each change of post office address. Failure to do so may result in the forfeiture of benefits otherwise due under the Plan.

16.20 Adequacy of Evidence. Evidence that is required of anyone under the Plan must be executed or presented by proper individuals or parties and may be in the form of certificates, affidavits, documents or other information that the person acting on such evidence considers pertinent and reliable.

16.21 Notice to Other Parties. A notice mailed first class, postage prepaid, to a Participant at his or her last address filed with the Plan Administrator will be binding on the Participant for all purposes of the Plan and will be deemed given on the date indicated on the notice or letter. A Claim for benefits, an election or other Notice mailed first class, postage prepaid, from a Participant to the Plan Administrator will be deemed given on the date of the postmark. Any party may also give a Notice as otherwise permitted under the Plan, and the Plan Administrator may establish rules relating to Notices, including when and how they may be given. Notices may be addressed to the Plan Administrator at the following address (or such other address as the Plan Administrator may designate from time to time):

Plan Administrator of the Hospitalization and Medical Expense Program
General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois
1901 Chestnut Avenue
Glenview, IL 60025

16.22 Waiver of Notice. Any notice under the Plan (including any Notice) may be waived by the person entitled to such notice. Acknowledgement of receipt of a notice will be deemed a waiver of any failures relating to the Plan-required means of giving such notice (but will not necessarily be deemed a waiver of the timeliness of such notice). Waiver of notice in one instance, however, will not be deemed to be a waiver in a later instance.

16.23 Successors. This Plan is binding on the Plan Sponsors, and on all persons entitled to benefits hereunder, and their respective successors, heirs and legal representatives.

16.24 Rules and Forms. The Plan Administrator will have the authority and responsibility to:

(a) adopt rules, regulations and policies for the administration of this Plan, in all matters not specifically covered by this Plan Document; and

(b) prescribe such Forms and records as are needed for the administration of the Plan.

IN WITNESS WHEREOF, pursuant to the authority delegated to the undersigned officer of the General Board by resolutions of the Board of Directors of the General Board adopted on July 13, 2013, the foregoing Hospitalization and Medical Expense Program is hereby restated on December 31, 2013, with effect as of January 1, 2014.

By: _____

Sarah S. Hirsen
General Counsel
General Board of Pension and Health Benefits of
The United Methodist Church, Incorporated in Illinois

Appendix A

Group Benefit Options January 1, 2014

The following are the Group Benefit Options offered under the Plan as of January 1, 2014 and the corresponding summary document that governs the terms of the Group Benefit Option to the extent that those terms do not conflict with this Plan. The Plan Administrator may amend this list from time to time.

I. **Preferred Provider Organization Benefit Option –** Blue Cross Blue Shield of Illinois governed by the applicable HealthFlex Benefits Booklet.

II. **Consumer-Driven Health Plan Benefit Option** – Blue Cross Blue Shield of Illinois governed by the applicable HealthFlex Benefits Booklet.

III. **Medicare Companion Plan Benefit Option –** Blue Cross Blue Shield of Illinois governed by the applicable HealthFlex Benefits Booklet.

IV. **Preferred Provider Organization Benefit Option –** United HealthCare governed by the applicable HealthFlex Benefits Booklet.

V. **Out of Area Benefit Option –** United HealthCare governed by the applicable HealthFlex Benefits Booklet.

VI. **Consumer-Driven Health Plan Benefit Option** – United HealthCare governed by the applicable HealthFlex Benefits Booklet.

VII. **Medicare Companion Plan Benefit Option –** United HealthCare governed by the applicable HealthFlex Benefits Booklet.

VIII. **Prescription Drug Plan P1 –** Catamaran governed by the HealthFlex Benefits Booklet applicable to the medical Group Benefit Option in which a Participant is enrolled.

IX. **Prescription Drug Plan P2 –** Catamaran governed by the HealthFlex Benefits Booklet applicable to the medical Group Benefit Option in which a Participant is enrolled.

X. **Mental and Behavioral Health HMO Benefit Option –** United Behavioral Health governed by the certificate of insurance issued by United Behavioral Health.

XI. **Mental and Behavioral Health Preferred Provider Organization Benefit Option –** United Behavioral Health governed by the certificate of insurance issued by United Behavioral Health.

XII. **Dental Indemnity Plan –** CIGNA governed by the HealthFlex Dental Benefits Booklet.

XIII. **Dental Preferred Provider Organization –** CIGNA governed by the HealthFlex Dental Benefits Booklet.

XIV. **Dental HMO –** CIGNA governed by the HealthFlex Dental Benefits Booklet.

XV. **Vision Plan –** VSP governed by the HealthFlex Benefits Booklet applicable to the medical Group Benefit Option in which a Participant is enrolled.

Amendment No. 1 to the HealthFlex Program

The General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois (the "General Board") maintains and administers the HealthFlex Program (the "Plan"). In accordance with the Plan and the Resolutions of the General Board, dated November 12, 2014 and July 17, 2015, Article VII of the Plan is hereby amended, effective January 1, 2015, as described below.

Amend Section 7.02 by deleting "applicable Grace Period and" from subsection (d), and by inserting the following definition where alphabetically appropriate and renumbering the sections and subsections as necessary:

"Carryover" means the amount that remains in a Participant's Medical Reimbursement Account at the end of any Plan Year which, up to a maximum of $500, shall be available during the following Plan Year.

Amend Section 7.03 to read as follows:

(a) ***Covered Expenses.*** The Medical Reimbursement Account Program shall only cover Medical Expenses incurred during the Period of Coverage, and shall only cover Medical Expenses incurred from Contributions made to this Medical Reimbursement Account Program by the Active Employee during such Period of Coverage plus any Carryover. Medical Expenses shall be considered incurred when the medical care or service giving rise to the Medical Expense is provided and not when the Active Employee is billed, charged for or pays for the Medical Expenses.

(b) ***Amount of Benefits.*** The maximum amount that an Active Participant may elect to contribute to his or her Medical Reimbursement Account in any Plan Year shall be $2,550 pursuant to §125(i) of the Code, as adjusted for increases in the cost of living in accordance with Code Section 125(i)(2), or a lesser amount as determined by the Plan Administrator in accordance with applicable law. The maximum amount that an Active Participant can have available in any Plan Year will be the amount of Contributions elected plus any Carryover. The minimum amount that an Active Participant may elect to contribute to his or her Medical Reimbursement Account in any Plan Year shall be $300 or as determined by the Plan Administrator in accordance with applicable law.

(c) ***Uniform Coverage.*** Reimbursement for Medical Expenses up to the amount elected by an Active Participant for a Period of Coverage shall be available at all times during the Period of Coverage (reduced by prior reimbursements during the Period of Coverage) regardless of the actual amounts by which an Active Employee's salary has been reduced and the amount that the Active Employee has contributed.

(d) ***Repayment of Excess Benefits.*** In the event that, as of the end of any Plan Year, the Plan Administrator determines that an Active Employee has received payments

under this Plan that exceed the amount that Active Employee elected to contribute for that Plan Year, the Plan Administrator shall give the Active Employee prompt written notice of any such excess amount, and the Active Employee shall repay the amount of such excess to the Plan Administrator or Recordkeeper within 60 days of such notification.

(e) ***Forfeitures.*** Amounts that remain in a Participant's Medical Reimbursement Account in excess of the allowed Carryover shall be forfeit after payment of all timely presented eligible Claims for Medical Expenses incurred during the applicable Period of Coverage, pursuant to Section 7.05, below. Forfeit amounts shall accrue to the Plan.

Amend Section 7.05 to read as follows:

(a) ***Claims for Reimbursement Benefits.*** Claims for Medical Reimbursement Account Program Benefits totaling a minimum amount as determined by the Plan Administrator may be made at any time during the Period of Coverage.

(b) ***Prior Payment Unnecessary.*** Active Employees need not actually make payment for reimbursable Medical Expenses before being reimbursed for them under the Plan. However, the Plan Administrator may require verification that expenses have been incurred.

(c) ***Claim Substantiation.*** The Plan Administrator or Claim Administrator shall require an Active Employee to substantiate claims for Medical Reimbursement Account Benefits under the Plan by submitting an appropriate Claim Form to the Plan Administrator or Claim Administrator, in such manner and form as prescribed by the Plan Administrator or Claim Administrator, setting forth:

(i) the individual on whose behalf Medical Expenses have been incurred;

(ii) the nature and date of such Medical Expenses;

(iii) the amount of the requested reimbursement; and

(iv) a statement that such Medical Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

All Claims for Medical Expenses shall be substantiated by copies of invoices, explanations of benefits, bills, receipts or other statements, or electronic evidence from a provider or other third party showing that the Medical Expenses have been incurred, when they were incurred and the amount of such Medical Expenses, together with any additional documentation that the Plan Administrator or Claim Administrator may request.

(d) ***Time Limit on Claiming Benefits.*** The Plan Administrator shall only reimburse Claims for Medical Reimbursement Benefits if the Active Employee presents such Claims during the Period of Coverage. In addition, the Plan Administrator may

reimburse eligible Claims submitted on or before April 30th of the year that follows the applicable Plan Year. This additional time period is called the "Run-Out Period." In its discretion, the Plan Administrator may treat reimbursements of claims for expenses incurred in the current Plan Year as reimbursed first from unused amounts credited for the current Plan Year and, only after exhausting these current Plan Year amounts, as then reimbursed from unused Carryover amounts from the preceding Plan Year.

Amend Section 7.06 by deleting "Grace Period and" from subsection (a).

IN WITNESS WHEREOF, the foregoing Amendment to the Plan is hereby adopted by the General Board, effective, January 1, 2015.

General Board of Pension and Health Benefits Of The United Methodist Church, Incorporated in Illinois

By: 

Name: Andrew Q. Hendren

Title: General Counsel

Date: 7/24/15