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**Section 223 Health Savings Account (HSA)**

**Effective as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_**

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**Section 223 Health Savings Account (HSA)**

**Effective as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_**

**Section 1. Establishment of the Plan**

 1.1. Establishment of the Plan. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the "Employer") hereby establishes a self-funded "Health Savings Account (HSA)" within the meaning of Section 223 & 106 of the Internal Revenue Code for its eligible Employees. The "Section 223 Health Savings Account (HSA)" and its terms and conditions shall become effective as of January 1, 20\_\_\_\_ , and shall apply to an eligible Employee's expenses only to the extent they are incurred after the HSA is deemed established with respect to the eligible Employee, except as permitted by applicable IRS guidance, and it will be known from and after the Effective Date as the "\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Section 223 Health Savings Account (HSA)" (the "Plan"), as set forth in this document.

 1.2 Purpose of Plan. The Plan has been established to reimburse eligible Employees for the cost of eligible expenses incurred by them or their Dependents that are Section 213(d) eligible expenses, including Over-the-Counter Drugs and medications, and certain insurance specified in Section 223(d)(2)(C) such as long term care insurance, COBRA coverage, health coverage while the Participant is receiving unemployment compensation, and certain health coverage once the Participant is age 65 or over, which includes premiums for Medicare (Part A, Part B and Medicare HMO) and employer sponsored health insurance are allowed under the Internal Revenue Code. As such, this Plan's qualified Benefit(s) are intended to meet the requirements for qualification under Code Section 223 and 106 and that Benefits provided the Employee hereunder are granted advantageous tax treatment under Code Section 223, wherever possible. Taxable distributions within the meaning of Section 223(f)(2) will be made only to the extent permitted under the Participant's agreement with the Employer.

 The Benefit provisions of this Plan are applicable only to the Employees of the Employer in current employment on or after the Effective Date and this Plan is established and maintained for the exclusive benefit of eligible Employees of the Employer. An Employee who retired or separated from employment prior to the Effective Date, shall not be entitled to participate in the Plan after the Plan Effective Date, until such time as the Employee is rehired by the Employer and then becomes eligible to participate in the Plan under the eligibility provisions set forth in Section 3.1. Retired employees may participate in a Section 223 Health Savings Account (HSA) under the terms and conditions of this Agreement.

**Section 2. Definitions**

 2.1 Definitions. Whenever used in the Plan, the following terms shall have the respective meanings set forth below unless otherwise expressly provided and when the defined meaning is intended, the term is capitalized.

 (a) The term "Benefits" means the qualified Eligible Expense reimbursement program offered to Employees under the terms and conditions of this Plan and which qualify for such statutory exclusion treatment under Code Section 223 and 106.

 (b) The term "Beneficiary" means the person or person designated by the Participant pursuant to Section 11.5 and 12.4.

 (c) The term "Qualified Beneficiary" for purpose of COBRA coverage is defined in Section 12.4.

 (d) The term "Code" means the Internal Revenue Code of 1986, as amended, and the regulations thereunder.

 (e) The term "Dependent" means an individual who is a dependent of the Participant under Code Section 152 and as a member is entitled to receive Eligible benefits under a Participant's election.

 (f) The term "Effective Date" means the date upon which this Plan was implemented and its terms became effective allowing participation by the Employees. Such date shall be identified when using the "Effective Date" term as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_.

 (g) The term "Employee" means a common-law employee of the Employer who is on the Employer's payroll. A retiree shall be considered an Employee for purposes of this Plan.

 (h) The term "Covered Employee" shall mean an Employee who is also eligible for COBRA coverage per Section 12.4.

 (i) The term "Employer" means \_\_\_\_\_\_\_\_\_\_\_\_, a \_\_\_\_\_\_\_\_\_ entity.

 (j) The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder. Title I of ERISA excludes governmental plans from coverage. The term "governmental plan" is defined in section 3 to include "a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. (Optional- This Plan is intended to be a "governmental plan" within the meaning of section 3 of ERISA, and, therefore excluded from ERISA Title I coverage pursuant to section 4 of ERISA.)

 (k) The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the applicable regulations provided for thereunder in Code Section 9801(f).

 (l) The term "Participant" means an Employee who meets the Plan eligibility requirements as set forth in Section 3.1.

 (m) The term "Plan" means the "\_\_\_\_\_\_\_\_\_\_\_\_ Section 223 Health Savings Account (HSA)" as set forth in this document.

 (n) The term Plan Committee known as the "Committee" means the person(s) appointed by the Employer, with the authority and responsibility to oversee and direct the operation and administration of the Plan. If no such person is named, the Committee shall be the Employer.

 (o) The term "Plan Year" means each twelve month continuous period beginning on (month), (day) and ending the same calendar year on (month), (day) and similarly each and every subsequent twelve calendar month period thereafter. The employer may designate in advance if the Plan Year will change and be less than a twelve month continuous period. This Plans terms and conditions are effective as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_ and the first Plan Year for the Plan will begin on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_ and end on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_, except as permitted by applicable IRS guidance.

 (p) The term "Eligible Expense" means the valid Eligible Expenses that participating members can submit under Section 213, including Over-the-Counter Drugs and medications, and certain insurance specified in Section 223(d)(2)(C) such as long term care insurance, COBRA coverage, health coverage while the Participant is receiving unemployment compensation, and certain health coverage once the Participant is age 65 or over, which included premiums for Medicare (Part A, Part B and Medicare HMO) and employer sponsored health insurance are allowed under the Internal Revenue Code. As such, this Plan's qualified Benefit(s) are intended to meet the requirements for qualification under Code Section 223 and 106 and that Benefits provided the Employee hereunder are granted advantageous tax treatment under Code Section 223, where possible. Taxable distributions within the meaning of Section 223(f)(2) will be made only to the extent permitted under the Participant's agreement with the Employer.

 (q) The term "Trust" means a Section 223 qualified tax-exempt trust with a Custodian and Trustee, the trust established to hold contributions made under the plan for the exclusive benefit of the employee participating in the Plan and from which all benefits can be distributed.

 2.2 Gender and Number. Except when otherwise indicated by the context, any masculine terminology shall also include the feminine and the definition of any term in the singular shall also include the plural.

**Section 3. Eligibility and Participation**

 3.1. Eligibility and Participation. Employee eligibility to participate in the Section 223 Health Savings Account (HSA) shall commence no earlier than the Plan Effective Date of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_, and an Employee shall be eligible to participate if such person satisfies (a) below.

 (a) Eligibility Rules, an Employee of the Employer working \_\_\_\_ (30) hours or more per week on a regular basis and who after \_\_\_\_\_ (30) days of employment becomes eligible for participation in the Employer's medical insurance plan and eligible benefits (provided the Employee has selected a high deductible medical insurance plan of at least $1000 single/$2000 family, is not eligible for any disqualifying coverage, is not a Dependent who can be claimed as such under Code Section 151, and has not attained age 65), shall be eligible to participate in the Plan following satisfaction of this paragraph's eligibility requirements.

 3.2. Duration.

 (a) Termination of Contributions by and for the Employee. The Participant's contributions while participating in the Plan shall terminate on the earliest of either: (i) the date an Employee ceases employment and makes an election to not continue with the Plan; (ii) the date an Employee ceases employment due to retirement and makes an election to not continue with the Plan; (iii) when an Employee ceases to meet the eligibility requirements of Section 3.1 of this Plan; (iv) the date this Plan is amended to exclude contributions by the Employee or the Plan is terminated; or (v) the effective date of the Employee's election not to participate in the Plan. Benefit Claims may continue to be reimbursed after contributions have stopped until the Account is exhausted unless the Employer requires that the Employee transfer the account to another Section 223 Custodian and under such a requirement, no further reimbursement of claims will be processed after Termination.

 (b) Participants who take a leave of absence either under the Family Medical leave Act (FMLA) or the Uniform Services Employment or Reemployment Rights Act (USERRA) may elect to continue participation in the Plan during their period of leave. Participants and Dependents eligible for coverage under the Plan who are otherwise eligible to continue coverage under the Plan of the Employer pursuant to the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) may continue to participate in the Plan during the period of such COBRA coverage. Amounts previously contributed which would otherwise continue to be contributed under this Section if the Participant were still employed may be paid to the Plan (a) as a single lump sum at the beginning of each year (or expected leave period), or (b) as monthly payments. The Employer contributions to the Plan ordinarily will continue during such leave (unless a disqualification provision applies). In addition, during a Participant's period of leave, he or she shall contribute the Participant's share of contributions to the Employer to pay for benefits.

**Section 4. Benefits**

 4.1. Annual Benefits Provided by Plan.

 (a) General. Subject to Sections 4.1(a)(2) and 4.1(b), a Participant's Annual Benefits with respect to a Plan Year shall be:

 (1). An Annual maximum amount which shall be the sum of any Employer contribution made to the HSA plus any Employee contribution, not less than $0.00, nor more than $\_\_\_\_\_\_ for single and $\_\_\_\_\_\_\_ for family per Plan Year per Participant based on a $\_\_\_\_ single deductible ($1000) and $\_\_\_\_\_ family deductible ($2000), prorated monthly beginning as of the effective date of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_. The amount set forth herein as the Annual Benefits maximum shall apply to each successive Plan Year starting on each subsequent (month), (day), until modified by the Employer prior to the start of a new Plan Year and notice given to eligible Employees prior to the start of such new Plan Year, except that in each successive year it shall include any unused contributions from the prior year(s), adjusted for earnings and reduced by any fees and expenses that are chargeable to the Participant's account. This Annual maximum amount shall apply to each Participant at the date participation in the Plan commences, subject to the limitations of Section 4.1(b), if applicable and shall be calculated on the # of months that the employee was covered under a high deductible medical insurance plan of at least $\_\_\_\_ for single and $\_\_\_\_\_for family deductible. Upon the discretion of the Employer; eligible individuals over age 55 may make an additional contribution which shall be $\_\_\_\_\_ ($500) up to age 65 when no additional contributions may be made, with such additional contribution adjusted for years after 2004 as provided in Code Section 223(b)(3)(B). Excessive contributions above the legal limits are subject to an annual excise tax of 6% until taken as taxable distribution or applied against a subsequent year's funding limit.

 (2) The annual maximum amounts that may be contributed by an Employee for a Plan Year period shall be limited as set out in paragraph 4.1(a)(1) by first reducing the maximum by any Employer contributions, in accordance with applicable law. Employer contributions shall be made at the sole discretion of the Employer and may be revised prior to the commencement of each new Plan Year and may be terminated at any time. Any such Employer contribution shall be uniformly applicable to all Participants in accordance with applicable law and Section 6's nondiscrimination rules. The maximum election amount set forth in paragraph 4.1(a)(1) shall also be subject to review and final approval by the governing body of the Employer. As such, the Employer reserves the right to take such action as it deems appropriate in order to assure compliance with the requirements of the Internal Revenue Code for favorable tax treatment of the Section 223 Health Savings Account (HSA). Eligible expense incurred but not paid from prior years may be eligible for reimbursement at the Employer's sole discretion and may be revised prior to the commencement of each new Plan Year. Interest may be earned and allocated to each Participant from year to year at the Employer's sole discretion and may be revised prior to the commencement of each new Plan Year. An Employee's contributions to the Plan shall be in cash and their investment earnings shall belong to the Employee. Rollovers from a MSA or other qualified plan allowed under the law shall be made in cash or other form acceptable to the custodian.

 (b) Account Balance. As of any time the Benefits and other permissible payments to or on behalf of a Participant shall be limited to the then current account balance of the Participant's Health Savings Account, as determined under Section 7. No portion of a Participant's account balance shall be forfeitable.

 4.2. Benefits. A Participant may receive the following benefit(s):

 (a) Eligible expenses.

 (i) Subject to subparagraph (ii), reimbursement of those "Eligible Expenses" of a Participant/Dependent shall include those which qualify for reimbursement under the Employer's Eligible high deductible plan but for the effect of a co-payment or deductible provision. The Participant is responsible for filing claim forms with the Benefit Claims Processor for reimbursement of eligible Section 213 expenses, including Over-the-Counter Drugs and medications, and certain insurance specified in Section 223(d)(2)(C) such as long term care insurance, COBRA coverage, health coverage while the Participant is receiving unemployment compensation, and certain health coverage once the Participant is age 65 or over, which included premiums for Medicare (Part A, Part B and Medicare HMO) and employer sponsored health insurance are allowed under the Internal Revenue Code. As such, this Plan's qualified Benefit(s) are intended to meet the requirements for qualification under Code Section 223 and 106 and that Benefits provided the Employee hereunder are granted advantageous tax treatment under Code Section 223, where possible. Taxable distributions within the meaning of Section 223(f)(2) will be made only to the extent permitted under the Participant's agreement with the Employer.

 (ii) An eligible expense shall be “incurred” when the claimant is furnished with the service giving rise to the claimed expense. Unless the Employer is using a Qualified full service Administrator, the responsibility for maintaining documentation and claims information of the expense incurred shall be with the Employee. If audited by the IRS, the employee agrees to provide said documentation to the IRS."

 In the event the Eligible plan is terminated, Benefit Claims may continue to be reimbursed after contributions have stopped until the Account is exhausted unless the Employer requires that the Employee transfer the account to another Section 223 Custodian/Trustee and under such a requirement, no further reimbursement of claims will be processed after Termination.

 An eligible expense shall be "incurred" when the claimant is furnished with the service giving rise to the claimed expense. Unless the Employer is using a Qualified full service Administrator, the responsibility for maintaining documentation and claims information of the expense incurred shall be with the Employee. If audited by the IRS, the employee agrees to provide said documentation to the IRS.

 4.3. Substitution. The Employer shall be substituted for all rights of a Participant to recover attorney fees and reimbursed expenses against any adverse party, so as to prevent double recovery by the Participant. A Participant shall not take any action prejudicial to such rights of the Employer and further they agree to do all acts necessary to preserve and take advantage of such rights. If payment has been made by the Employer plan in such instances, and if the adverse party reimburses the Participant directly, the Employer shall have the right to recover such payment from such Participant receiving the double recovery on behalf of the Employer plan. If such payment was made by the Participant's Health Savings Account, and if the adverse party reimburses the Participant directly, the Employer shall have the right to recover such payment from such Participant receiving the double recovery in order to restore the amount to the Participant's Health Savings Account.

 4.4. Notification of Employees. The Employer shall communicate in writing to all eligible Employees a summary of the terms and conditions of the Plan.

 4.5. Rights of Employees.

 (a) This Plan shall not be deemed to be a contract of employment between the Employer and any Employee or to be a consideration or an inducement by the Employer to obtain the employment of any Employee. Nothing contained in this Plan shall give any Employee the right to be retained in the service of the Employer or interfere with the right of the Employer to discharge any Employee at any time regardless of the effect such discharge will have upon such Participant.

 (b) Except as provided in this Section 4.5 or as otherwise provided in this Plan, any rights granted to Employees under this Plan are legally enforceable. In addition, Employees shall have the right to examine without charge the Plan document. The Employee may also obtain copies of the Plan upon written request to the Employer and payment of a reasonable charge for copies.

 (c) To the extent permitted in the Participant's agreement with the Employer, the Participant's Health Savings Account may be rolled over to a Health Savings Account maintained by another custodian.

 4.6 Taxation. It is the Employer's intent that the benefits provided in this Plan receive favorable tax treatment by the Employer under Section 162 of the Code and may be excluded from the Participant's taxable gross income under Sections 223 and 106 of the Code, except for taxable distributions that are made consistent with the agreement between the Participant and the Employer, as amended or supplemented and all provisions herein shall be interpreted consistently with this intent.

**Section 5. Benefit Claims and Application for Payment**

 5.1. Allowable Benefit Claims. Claims for reimbursement of qualified Eligible Expenses incurred during the Plan Year during the period of time the Participant was employed by the Employer (unless the Participant was retired, or was qualified for COBRA continuation coverage as more fully set forth in Section 12), shall be submitted not later than the earlier of either; (1) the 90th day after the end of the Plan Year; or (2) the last day of the Plan Year in which the Participants' termination of employment with the Employer took place and did not elect to continue the Plan (unless failure to submit was caused by the Participant's death) or at the discretion of the Employer and determined prior to the current plan year. Claims shall be submitted to the Employer pursuant to the claim requirements set forth in Section 5.2. No reimbursement of claims will be paid in advance of the time when they are actually incurred. Failure to submit claims during the time period established by this Section 5.1 shall deprive a Participant of a claimed expense reimbursement to which such Participant might otherwise be entitled for the Plan Year period.

 5.2. Application for Payment. Each Participant eligible to receive a payment for reimbursement of Eligible Expenses under the Plan shall apply for such payment by using an Employer approved Debit, credit, or direct payment system to the Provider, or by completing a claims form obtained from the Employer, requesting reimbursement for qualified Eligible Expenses incurred while participating in this Plan. If the Employer is using a Qualified full Service Administrator, each such Participant shall also furnish the Employer with such documents, evidence, data or information in support of such application as the Employer considers necessary or desirable including bills from an independent third party stating that the expense has been incurred, the date incurred and the amount of such statement. The forms shall contain such evidence as the Committee shall deem necessary to substantiate the nature, the amount and timeliness of any expenses that may be submitted for reimbursement.

 If the claim form or filing is incomplete or improperly filed with the Qualified full Service Administrator or their Benefit Claims Processor, a written explanation of the information necessary to complete the claim and why such information or material is necessary to complete the claim process will be sent to the Participant. This written notification to the Participant will be processed and mailed within forty-five (45) days after receipt of the incomplete claim form in the office of the Benefit Claims Processor. These guidelines should be followed in all cases unless good cause exists for a variance and application of different procedures may be appropriate under those circumstances.

 Claim payments shall be made as soon as administratively feasible after the required claim forms have been received and processed by the Benefit Claims Processor.

 In the event that the Participant uses a Debit or Credit card for payment of the Eligible Expenses incurred, the Participant agrees to submit the required claim form and information necessary to complete the form as required by the Qualified full Service Administrator or their Benefit Claims Processor and in accordance with IRS rulings.

**Section 6. Nondiscrimination Rules**

 6.1. Prohibition of Discrimination. The availability of this Plan to Employees shall not be discriminatory in terms of the availability of Employer contributions to Similarly Situated Employees as provided in Code Section 4980G with regards to non-discrimination compliance. Employee contributions shall not be considered for purposes of discrimination testing, even if made on a pre-tax basis.

 6.2 Similarly Situated Employees. The term "Similarly Situated" as applied herein shall mean that it is permissible to differentiate coverage and contributions between groups of similarly situated individuals such as single versus family coverage, adjustments for part-time, part-year, or seasonal Employees so long as the distinction is not based on individual or health factors. In distinguishing among Employee classifications, the provisions of the Plan must base such distinctions on bona-fide employment based classifications consistent with the Employers usual business practice(s).

**Section 7. Accounts and Records of the Plan**

 The Employer shall establish and maintain accounts in the name of each Participant at the time such Employee first becomes a Participant in the Plan.

 The Employer shall maintain records with respect to each Participant itemizing and identifying all contributions by both the Employee and Employer, any investment returns on contributions, any fees, taxable distributions within the meaning of Section 223(f)(2) will be made only to the extent permitted under the Participant's agreement with the Employer, claims requests for payments and the dates thereof and a record of the payments made through the Plan as claims reimbursements during such Plan Year period as those amounts are charged to each individual account of a Participant and paid out on behalf of such Participant. Based on the foregoing, the Employer shall determine the Participant's current account balance in the Participant's Health Savings Account. The account balance shall be increased by contributions, shall be adjusted for investment returns (including negative adjustments for losses), and shall be reduced by: (i) Benefits that are paid, (ii) other permitted distributions (including rollovers), and (iii) fees and expenses.

**Section 8. Contributions and Financing**

 Contributions for Plan Benefits. Employees may contribute but are not presently required to contribute to the Plan from the Employees' Compensation in order to receive benefits from the Plan. The Employer shall also have the right to contribute funds to be used in the payment of benefits under the terms of the Plan. However, the Employer reserves the right to enter into a contract with one or more insurance companies for the purpose of providing any benefits under the Plan at any time as may be appropriate herein. Contributions to the Plan and their investment earnings shall belong to the Employee, and may be transferred to the spouse/former spouse, in connection with a divorce or a legal separation instrument, or to the Beneficiary at the death of the Employee.

**Section 9. Non-Alienation of Benefits**

 Except for a Participant's right to transfer the Participant's account as provided in Section 8.1(a), no benefit payable under the provisions of the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge shall be void; nor shall such benefits be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Participant, Dependent or beneficiary, including claims of creditors, claims of alimony or support and any like or unlike claims.

**Section 10. Administration**

 10.1. Administration. The Committee shall administer the Plan and shall have the authority to exercise the powers and discretion conferred on it by the Plan and shall have such other powers and authorities necessary or proper for the administration of the Plan as shall be determined by the Employer and which are not inconsistent with the written provisions of this Plan.

 The Committee shall keep complete records and accounts necessary or proper to administer the Plan and shall render such statements to Participants as are required hereunder.

 The Committee may adopt such rules and regulations for the administration of the Plan as it shall consider advisable and shall have full power and authority to enforce, construe, interpret and administer the Plan. All interpretations under this Plan and all determination of fact made in good faith by the Employer shall be binding on the Participants, their beneficiaries, and all other persons interested.

 The Employer may adopt such rules and regulations for the conduct of the Plans business as it deems advisable and may employ such agents, attorneys, accountants, investment advisers or other persons (who also may be employed by the Employer) as in its opinion may be desirable for the administration of the Plan and may pay any such person reasonable compensation. The Employer may delegate to the Committee, or any agent, attorney, accountant or other person selected by it, any power or duty vested in, imposed upon, or granted to it by the Plan.

 10.2. Claims Procedures Applicable to Plan. This Section 10.2 shall not apply to the Group Health Insurance Plan and other full insured eligible plans and such underlying component benefit plans or policies. Procedures under this Section 10.2 will be applicable to benefits available under this Plan for matters requiring a determination of any Plan eligibility and participation issues arising under the terms of this Plan document.

 (a) Procedure for Filing a Claim for Benefits. Any Employee, Dependent or beneficiary may file a claim for a benefit to which such individual believes is a qualified claim, but that has been rejected under the Plans terms and conditions. Such a claim must be in writing and delivered to the Committee, in person or by mail, postage paid. Within sixty (60) days after receipt of such claim, the Committee shall send to the claimant, by mail, postage prepaid, notice of any determination made by the Committee regarding such claim. The Committee shall have full discretion to interpret ambiguous Plan terms and to deny or grant a claim in whole or in part. Benefits under this Plan will be paid only if the Committee decides in their discretion that the individual making such a claim, is entitled to receive the claimed Benefits. If notice of the denial of a claim is not furnished in accordance with this Section 10.2(a), the claim shall be deemed denied and the claimant shall be permitted to exercise the right to review pursuant to Section 10.2(c).

 (b) Requirement for Written Notice of Adverse Benefit Determination. The Committee shall provide a written notice to every claimant filing a claim pursuant to this Plan's Section 10.2 procedures, whose claim is denied by the Committee pursuant to this Section 10.2. Such written notice shall set forth in a manner calculated to be understood by such claimant, the following information:

 (i) The specific reason or reasons for the adverse benefit determination;

 (ii) Specific reference to pertinent Plan provisions on which the determination is based;

 (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary, and

 (iv) An explanation of the Plan claim review procedure.

 (c) Right to Request Hearing on Adverse Benefit Determination. Within sixty (60) days after the receipt by the claimant of the Adverse Benefit Determination regarding such claim, the claimant or an authorized representative may make a written application to the Committee, in person or by certified mail, postage prepaid, requesting review of such adverse benefit determination. The claimant will then have the opportunity to review all Plan documents, records or other pertinent information relevant to this matter. Finally the claimant will be allowed to submit records, documents and written comments supporting such claim.

 (d) Review of Adverse Benefit Determination. Upon receipt of all material necessary for a full review of the adverse benefit determination, the Committee shall make a review that takes into account all comments, documents, records and other information submitted by the claimant. After a full and fair review of the matter, the decision on such review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent plan or insurance policy provisions on which the decision was based. The decision upon review shall be made not later than sixty (60) days after the Committees receipt of a request for a review. If the appeal results in an adverse benefit determination on review and the claimant has fully exhausted all administrative review procedures set forth herein, then and only then may a claimant bring a civil legal action to review the adverse benefit determination.

 10.3. Indemnification. To the extent permitted by law, Committee members who are Employees of the Employer and all agents and representatives of the Employer, shall be indemnified by the Employer and saved harmless against any claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except for claims arising out of gross negligence, willful neglect, or willful misconduct. The Employer reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

 10.4. Expenses of Administration. Any reasonable expenses incurred in the administration of the Plan shall be paid by and become the responsibility of the Employer except for those fees or expenses have been determined by the Employer to be payable from the Employee's contributions or from the HSA account balance.

 10.5. Right of the Employer to Inspect the Records of the Plan. The Employer may at its own expense and at any reasonable time, cause an examination of the books and records of the Plan to be made by such attorneys, accountants, auditors or other agents as it shall select for that purpose and may cause a report of such examination to be made.

**Section 11. Changes in the Plan**

 11.1. Plan Continuation. The Employer expects the Plan to continue indefinitely, but since future conditions affecting the Employer cannot be anticipated or foreseen, the Employer must necessarily and does hereby reserve the right to amend, modify or terminate the Plan, as set forth in Sections 11.2 and 11.3, below. Nothing in this Plan is intended or shall be construed as granting to any Participant, Employee or any other individual, Plan rights or Benefits that are or which are claimed to have become vested (all such claims are denied) under the terms of this Plan.

 11.2. Employer's Right to Amend. The Employer reserves the right to amend at any time, any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Committee in accordance with its normal procedures for transacting business or by written consent of all Committee members. Such amendments may apply in limited cases, retroactively when such is necessary to maintain Plan regulatory compliance and will not deprive Participants of benefits they are entitled to or have rights to and may realize prospectively.

 11.3. Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan, at any time and for any reason, as such actions will properly meet the regulatory and statutory requirements for such Plan termination. Any such termination shall be in writing and shall be approved by the Committee. Benefit Claims may continue to be reimbursed after contributions have stopped until the Account is exhausted unless the Employer requires that the Employee transfer the account to another Section 223 Custodian and under such a requirement, no further reimbursement of claims will be processed after Termination.

 11.4. Effective Date of Amendment or Termination. Any such Plan amendment, cessation of operations or outright Plan termination shall be effective as of such date as the Employer shall determine. No Plan amendment, cessation of operations or Plan termination shall permit the return to the Employer of any account balances which are to be used for the exclusive benefit of the Participants and their beneficiaries.

 11.5. Beneficiary. Each Participant shall designate upon such forms as may be provided for that purpose by the Committee a Beneficiary or Beneficiaries who are to receive, in the event of his or her death, payment of a reimbursement to which he or she is entitled under the Plan, or a cash payment of unused account balances. Benefit Claims may continue to be reimbursed after contributions have stopped until the Account is exhausted unless the Employer requires that the Employee transfer the account to another Section 223 Custodian and under such a requirement, no further reimbursement of claims will be processed after Termination. The designation of a Beneficiary shall not be effective for any purpose unless and until it has been filed with the Committee. In the event that a Participant fails to designate a Beneficiary in the specified manner, or if for any reason such designation shall be legally ineffective, or if such Beneficiary shall either predecease the Participant or die simultaneously with him or her, then, for the purposes of the Plan, distribution shall be made by the Committee to the Participant's spouse (if any). If there is no spouse, at the discretion of the Committee, the benefits shall be paid to the estate of such deceased Participant. In the event the Committee elects not to make any such payments, the Committee may elect to have a court of applicable jurisdiction determine to whom a payment or payments shall be paid.

 In the case of any insurance policy which permits or requires the naming of a beneficiary, it shall be the responsibility of the Participant to see that a Beneficiary or Beneficiaries are named. The Employer shall not be liable for any loss or cost which may result from such failure. The Employer's responsibility shall be limited to joining in the execution of any documents as requested by a Participant or insurance carrier in order to carry out the purposes of this Plan.

 11.6. Exercise of Discretion to be Absolute and Uniform. In each case in which discretion is granted to the Committee, such discretion shall be sole, absolute, and uncontrolled and shall be exercised in a uniform manner so as not to discriminate either for or against any Participant. All interpretations under this Plan and all determinations of fact made in good faith by the Administrator shall be binding on the Participants, their Beneficiaries, and all other persons interested.

**(OPTIONAL) Section 12. Continuation of Coverage under COBRA**

 12.1. Continuation of Coverage. The COBRA continuation coverage will not be applicable to certain Participants in this Plan. However, the intent of this Section 12, is to extend continuation rights required by COBRA to qualifying Plan Participants. In the event that the Employer and the Participant's Health Savings Account are subject to COBRA, the following shall apply:

 12.2. Continuation Coverage Post Termination of Normal Participation. During any Plan Year in which the Employer is subject to Code Section 4980B, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under the Plan (or other group health plan subject to COBRA) upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage hereunder. The COBRA Continuation Coverage and the provisions herein, will apply only to the type and level of coverage such Participant coverage under the Plan was actually provided on the day before the qualifying event. Also, Section 12.3 sets forth additional rules limiting the obligation to provide COBRA Continuation Coverage to Participants of non-qualifying Benefits in this Plan.

 12.3. COBRA Coverage Not Applicable to Certain Plan Benefits. COBRA continuation coverage will not be offered to Plan Participants under the following circumstances:

 (a) Availability of COBRA in Plan Year in Which Qualifying Event Occurs. Available COBRA continuation coverage will be offered to a Qualified Beneficiary in the Plan Year in which the Qualifying Event occurred.

 (b) Unavailability of COBRA in Subsequent Plan Years. COBRA continuation coverage will not be offered to a Participant in any Plan Year following the Plan Year in which the Qualifying Event occurs (thus even if COBRA is offered for the Plan Year in which the qualifying event occurs, the COBRA coverage will cease at the end of the Plan Year and cannot be continued for the next Plan Year) if:

 (i) HSA is Exempt From HIPAA. The Plan is exempt from HIPAA (i.e., a high deductible medical plan is available in addition to the HSA, and the HSA benefit does not exceed two times the Employee's contribution or, if greater, the Employee's contribution plus $500); and

 (ii) COBRA Premium Equals or Exceeds Plan Benefit. If for the Plan Year in which the Qualifying Event occurs, the maximum amount the Qualified Beneficiary could be required to pay for a full year of COBRA continuation coverage equals or exceeds the maximum benefit available to the Qualified Beneficiary for the Plan Year.

 12.4. Definition of "Qualified Beneficiary". A "Qualified Beneficiary" is any person who is, as of the day before a Qualifying Event: (a) an Employee of the Employer covered under a health plan offered under the Plan as of such day (such persons are called "Covered Employees"), or (b) the Spouse or Dependent of the Covered Employee who on the day before the Qualifying Event for the Covered Employee is a beneficiary under the Plan. A Covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours, an absence from work due to disability, a temporary layoff, is a reduction of hours of a Covered Employee's employment if there is not an immediate termination of employment. A child born to or placed for adoption with a Covered Employee during Continuation Coverage will also be a Qualified Beneficiary. A retiree or other former Employee actively participating in the Plan by reason of a previous period of employment will be treated as a "Qualified Beneficiary."

 12.5. Definition of a "Qualifying Event". Any of the following shall be considered as a "Qualifying Event" if, but for COBRA continuation coverage, the event would result in the loss of coverage by a Qualified Beneficiary:

 (a) death of a Covered Employee;

 (b) termination (other than by reason of gross misconduct) of the Covered Employee's employment or such events which are considered to be a "reduction of hours of employment" and which shall include an absence from work due to disability, a temporary layoff, or any other reason causing a reduction of hours of the Employee's employment (if there is not an immediate termination of employment).

 (c) divorce or legal separation of a Covered Employee from the employee's spouse;

 (d) a Covered Employee becoming eligible to receive Medicare benefits under Title XVIII of the Social Security Act; or

 (e) a Dependent child of a Covered Employee ceasing to be a Dependent. In the case of any person treated as a Covered "Employee" but who is not a common-law employee, termination of "employment" means termination of the relationship that originally gave rise to eligibility to participate in the Plan (or other group health plan subject to COBRA).

 12.6. Benefits Available Under COBRA Continuation Coverage. Each person who is eligible to elect to continue coverage under this Section 12, shall have the right to continue the level of coverage in effect for the Covered Employee on the day before the Qualifying Event (or a lesser level of coverage that is available pursuant to an election offered to a similarly situated active employee). If a Qualified Beneficiary of another group health plan maintained by the Employer is prevented from receiving a previous level of benefits due to a change in Plan Benefits or Plan termination, such individual will be entitled to elect any available level of coverage under the Plan. A premium for COBRA Continuation Coverage shall be charged to Employees and Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Committee and permitted by applicable law.

 12.7. Notice Requirements.

 (a) When an Employee becomes covered under the Plan (or any other group health plan subject to COBRA), the Committee must inform the Participant (and spouse, if any) in writing of the rights to continued coverage, as described in this Section 12.

 (b) The Employer shall give the Committee, written notice of a Qualifying Event within thirty (30) days of the occurrence date.

 (c) Within fourteen (14) days of receipt of the Employer's notice, the Committee shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the Plan (or any other group health plan subject to COBRA), as well as a recital of the rights of any such Beneficiary to elect Continuation Coverage, under the provisions of Code Section 4980B and ERISA Section 601 and in accordance with the terms of this Plan.

 (d) In the case of a Qualifying Event described in Section 12.5(c) or 12.5(e), a Covered Employee or a Qualified Beneficiary who is a Dependent of such Employee must notify the Employer within sixty (60) days of the occurrence thereof. The Committee shall give written notification of COBRA Conversion Coverage rights to any other affected Qualified Beneficiaries within fourteen (14) days of receipt of the notice described in this Section 12.7(d).

 Notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

 12.8. Election Period. Any Qualified Beneficiary entitled to COBRA Continuation Coverage shall have sixty (60) days from the date of the notice required by Section 12.7, in the case of occurrence of a Qualifying Event, in which to return a signed election to the Committee indicating the choice to continue benefits under this Plan.

 12.9. Duration of Continuation Coverage. Except as otherwise provided in this Plan, COBRA Continuation Coverage shall extend for a period of 18 months after the date that regular coverage ceased due to occurrence of the initial Qualifying Event described in Section 12.5(b), unless during such 18 month period a subsequent Qualifying Event occurs or there is a disability extension in accordance with the last sentence of Section 4980B(f)(B), in which case the right to extend coverage beyond 18 months shall be available to the Beneficiary (up to 29 months for disability and up to 36 months in the case of a subsequent Qualifying Event not described in Section 12.5(b)). Except as otherwise provided in this Section 12.9, in the case of a Qualifying Event not described in Section 12.5(b), COBRA Continuation Coverage shall extend for a period of 36 months after the date that regular coverage ceased due to the occurrence of the Qualifying Event. In no event, however, shall COBRA Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

 12.10. Automatic Termination of Continuation Coverage. COBRA Continuation Coverage shall automatically cease if (a) the Employer no longer offers group health coverage to any of its employees; or, (b) the required premium for COBRA Continuation Coverage for a particular coverage is not paid within thirty (30) days of the date due or within forty-five (45) days after the initial election of Continuation Coverage made pursuant to Section 12.8 (whichever is later); or, (c) an electing Qualified Beneficiary becomes covered under another group health plan other than a group health plan which may limit a Qualified Beneficiary's coverage because it involves a pre-existing condition; or (d) an electing Qualified Beneficiary becomes eligible to receive benefits under Medicare.

**Section 13. Miscellaneous**

 13.1. Plan Interpretation. All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided for in Section 13.7.

 13.2. No Guarantee of Tax Consequences. Neither the Benefit Claims Processor nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excluded from the Participant's gross income for federal, state or local income tax purposes, or that any other federal, state, or local tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excluded from the Participant's gross income for federal, state and local income tax purposes, and to notify the Employer if the Participant has any reason to believe that any such payment is not so excludible. Notwithstanding the foregoing, the rights of a Participant under this Plan shall be legally enforceable as set forth in Section 4.5.

 13.3. Funding. As required by law, contributions to the Plan will be placed in a tax-exempt qualified trust with a qualified Trustee and Custodian. Furthermore and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Benefit Claims Processor to maintain any fund or segregate any amount for the benefit of any Participant until at that time that the Employee desires to cease employment and continue the Plan. Participant or other Qualified Dependents shall have a claim against, right to, or security or other interest in their Contributions and earnings for which any payment under the Plan may be made.

 13.4. Insurance Control Clause. In the event of a conflict between the terms of this Plan and the terms of an insurance contract of a particular insurer whose product is then being used in conjunction with this Plan, the terms of such insurance contract shall control as to those Participants receiving coverage under such insurance contract. For this purpose, said insurance contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured and if any, the benefits Participants are entitled to and the circumstances under which the insurance terminates.

 13.5. Captions. The Captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge, or describe the scope or intent of the Plan, nor in any way shall such captions affect the Plan or the construction of any provisions thereof.

 13.6. Inability to Locate Payee. If the Employer shall be unable, within one (1) year after any amount becomes due and payable from the Plan to a Participant, to make payment because the identity or whereabouts of such person cannot be ascertained, the Employer shall allocate the payment to the Participant's Plan account balance.

 13.7. Illegality of Particular Provision. The illegality of any particular provision of this Plan shall not affect the other provisions of the Plan, but the Plan shall be construed in all respects as if such invalid provision was omitted.

 13.8. Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or all allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Employer shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, (as allowed by the Code) or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which such person is properly entitled to under the terms of the Plan.

 13.9. Applicable Laws. To the extent not preempted by ERISA, the provisions of this Plan shall be construed, administered and enforced according to applicable federal law and the laws of the State of \_\_\_\_\_\_\_\_\_\_\_\_.

 13.10 Adoption by Affiliated Employer. Upon the approval of the Employer, this Plan may be adopted by any Affiliated Employer. The Affiliated Employer shall execute and deliver to the Employer a supplemental agreement providing for the adoption of this Plan and such other documents as the Employer shall deem necessary or desirable. The provisions of this Plan shall be applicable to such organizations to the extent such provisions are provided for in the adoption agreements.

 As used in this Plan, "Affiliated Employer" shall mean a company or business unit that is (a) a member of a controlled group or companies, or (b) under common control, within the meaning of Code Section 414(c), with the Employer; or (c) a member of an affiliated service group, within the meaning of Code Section 414(m), that includes the Employer.

 IN WITNESS WHEREOF, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, by and through its authorized officer, has caused this instrument to be executed and to become effective as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

 By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_