

**VERDE VALLEY EMPLOYEE BENEFIT POOL (VVEBP)  
FLEXIBLE BENEFITS PLAN  
SUMMARY PLAN DESCRIPTION/MASTER PLAN DOCUMENT**

**JULY 1, 2008**

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## **SECTION I—INTRODUCTION**

The Participating Employers in the Verde Valley Employee Benefit Pool have adopted this Plan effective July 1, 2008, to recognize the contributions made to the Employers by their Employees. Its purpose is to reward them by providing benefits for those Employees who qualify hereunder and their dependents and beneficiaries. The concept of this Plan is to allow Participants to choose among different types of benefits based on their own particular goals, desires and needs. The benefits that are available are outlined in this Master Plan/Summary Plan description. This Plan description also contains other important information concerning the Plan, such as the rules that must be satisfied before an Employee can join and the laws that protect the Employee's rights. The Plan shall be known as Verde Valley Employee Benefit Pool ("VVEBP" or "Pool") Flexible Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which a Participant elects to receive under the Plan be includible or excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

The Plan Trustees have made a decision to align the operation of this employee benefit plan with the Plan's fiscal year. Thus, this is a "12 Month Plan Year" that will operate beginning on July 1, 2008. Details about the rights, responsibilities and consequences of this "12 Month Plan Year" are set-out in more detail below and have been previously summarized for Plan Participants in separate Employee Communications Packets.

## **SECTION II—PARTICIPATION**

### **A. Eligibility**

Any individual shall be eligible to participate hereunder as of the date such individual satisfies the eligibility conditions for the Verde Valley Employee Benefit Pool's ("Pool") group medical plan, the eligibility provisions of which are specifically incorporated herein by reference.

### **B. Effective Date of Participation**

An individual shall become a Participant effective as of the entry date under the Pool's group medical plan, the entry date provisions of which are specifically incorporated herein by reference.

### **C. Application to Participate**

An individual who is eligible to participate in this Flexible Benefits Plan ("Plan") shall, during the applicable election period, complete an application to participate and election of benefits form which the Plan Administrator shall furnish to the eligible individual. The election made on such form shall be irrevocable until the end of the applicable 12 Month Plan Year unless the Participant is entitled to change benefit elections pursuant to the Change of Elections section hereof.

An eligible individual shall also be required to execute a salary redirection agreement during the election period for the 12 Month Plan Year during which such eligible individual wishes to participate in this Plan. Any such salary redirection agreement shall be effective for the first pay period beginning on or after the individual's effective date of participation and continue throughout the 12 Month Plan Year.

**D. Termination of Participation**

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- a. termination of employment;
- b. employee's death; or
- c. termination of this Plan.

**E. Termination of Employment**

If a Participant's employment with the employer is terminated for any reason other than death, his participation in the Plan shall be governed in accordance with the following:

- a. With regard to the Dependent Care Assistance Program, the Participant's participation in the Plan shall cease and no further salary redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for the remainder of the 12 Month Plan Year in which such termination occurs, until the balance in his or her Dependent Care Assistance Account is depleted. The Participant must submit all Plan reimbursement claims within ninety (90) days of termination of employment. With regard to the Health Care Reimbursement Plan, the Participant may elect to continue participation in the Plan.
  - 1) If the Participant elects to continue participation in the Health Care Reimbursement Plan for the remainder of the 12 Month Plan Year in which such termination occurs, the Participant may continue to seek reimbursement from the Health Care Reimbursement Fund. The Participant shall be required to continue to make contributions to the fund based on the benefit elections in place prior to the beginning of the 12 Month Plan Year.
  - 2) If the Participant does not elect to continue participation in the Health Care Reimbursement Plan for the remainder of the 12 Month Plan Year in which such termination occurs, the Participant's participation in the Plan shall cease and no further salary redirection contributions shall be made. However, such Participant may submit claims for eligible expenses incurred during the portion of the 12 Month Plan Year preceding the date of termination.
- b. In the event a Participant terminates participation in the Health Care Reimbursement Plan during the 12 Month Plan Year, if salary redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any salary redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.
- c. This section shall be applied and administered consistent with such further rights to which a Participant and the Participant's dependents may be entitled to pursuant to 26 U.S.C. Section 4980B and the section of this Plan entitled "CONTINUATION COVERAGE RIGHTS UNDER COBRA."

## **F. Death**

If a Participant dies, participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his estate, may submit claims for expenses or benefits for the remainder of the 12 Month Plan Year or until the cafeteria plan benefit dollars allocated to each specific benefit are exhausted. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may designate the Participant's spouse, one of Participant's dependents or a representative of the estate.

## **SECTION III—CONTRIBUTIONS TO THE PLAN**

### **A. Salary Redirection**

Each Participant must elect to have his salary reduced pursuant to a salary redirection agreement. Such salary redirection agreement must be executed during the applicable election period. The amount of the salary redirection a Participant may elect for each 12 Month Plan Year shall be up to \$2,500. These contributions shall be converted to cafeteria plan benefit dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections.

Any salary redirection shall be determined prior to the beginning of a 12 Month Plan Year (subject to initial elections) and prior to the end of the election period and shall be irrevocable for such 12 Month Plan Year. However, a Participant may revoke a benefit election or a salary redirection agreement after the 12 Month Plan Year has commenced and make a new election with respect to the remainder of the 12 Month Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under the Participant Elections section of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary redirection amounts shall be contributed on a pro rata basis for each pay period during the 12 Month Plan Year. All individual salary redirection agreements are deemed to be part of this Plan and incorporated by reference hereunder.

### **B. Application of Contributions**

As soon as reasonably practical after each payroll period, the Pool shall apply the salary redirection to provide the benefits elected by the affected Participants. Any contribution made or withheld for the Health Care Reimbursement Fund or Dependent Care Assistance Account shall be credited to such fund or account.

### **C. Periodic Contributions**

Notwithstanding the requirement provided above and in other section of this Plan that salary redirections be contributed to the Plan by the participating employer on behalf of an employee on a level and pro rata basis for each payroll period, the employer and Plan Administrator may implement a procedure in which salary redirections are contributed throughout the 12 Month Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Care Reimbursement Plan, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the 12 Month Plan Year. In the event salary redirections are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such salary redirections as they relate to the Health Care Reimbursement Account(s).

## **SECTION IV—BENEFITS**

### **A. Benefit Options**

Each Participant may elect to have the amount of his other cafeteria plan benefit dollars applied to any one or more of the following optional benefits:

- Health Care Reimbursement Plan
- Dependent Care Assistance Program
- Health Savings Account Benefit

### **B. Health Care Reimbursement Plan Benefit**

Each Participant may elect coverage under the Health Care Reimbursement Plan option.

### **C. Dependent Care Assistance Program Benefits**

Each Participant may elect coverage under the Dependent Care Assistance Program option.

### **D. Health Savings Account Benefit**

Each Participant may elect to have amounts contributed to a Health Savings Account, and the amounts shall be subject to the terms of the Health Savings Account established by the Participant.

### **E. Nondiscrimination of Requirements**

- a. It is the intent of this Plan to provide benefits to a classification of Participants while not discriminating in favor of any group as provided in 26 U.S.C. Section 125.
- b. It is the intent of this Plan **not to** provide qualified benefits as defined under 26 U.S.C. Section 125 to key employees in amounts that exceed 12.5% of the aggregate of such benefits provided for all eligible Participants under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.
- c. If the Plan Administrator deems it necessary to avoid discrimination or possible taxation to key employees or a group of Participants in whose favor discrimination may not occur in violation of 26 U.S.C. Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable benefits in order to assure compliance with this section. Any act taken by the Plan Administrator under this section shall be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any election or reduce contributions or non-taxable benefits, it shall be done in the following manner. First, the non-taxable benefits of the affected Participant (either an employee who is highly compensated or a key employee, whichever is applicable) who has the highest amount of non-taxable benefits for the 12 Month Plan Year shall have his non-taxable benefits reduced until the discrimination tests set forth in this section are satisfied or until the amount of his non-taxable benefits equals the non-taxable benefits of the affected Participant who has the second highest amount of non-taxable benefits. This process shall continue until the nondiscrimination tests set forth in this section are satisfied. With respect to any affected Participant who has had benefits reduced

pursuant to this section, the reduction shall be made proportionately among Health Care Reimbursement Plan Benefits and Dependent Care Assistance Program Benefits. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

## **SECTION V—PARTICIPANT ELECTIONS**

### **A. Initial Elections**

An individual who meets the eligibility requirements on the first day of, or during, a 12 Month Plan Year may elect to participate in this Plan for all or the remainder of such 12 Month Plan Year, provided the individual elects to do so before his effective date of participation. However, if such individual does not complete an application to participate and benefit election form and deliver it to the Plan Administrator before such date, that individual's election period shall extend thirty (30) calendar days after such date, or for such further period as the Plan Administrator shall determine and apply on a uniform and nondiscriminatory basis. However, any election during the extended thirty (30) day election period shall not be effective until the first pay period following the later of such Participant's effective date of participation or the date of the receipt of the election form by the Plan Administrator, and shall be limited to the benefit expenses incurred for the balance of the 12 Month Plan Year for which the election is made.

### **B. Subsequent Annual Elections**

While the Plan Trustees reserve the right to amend and/or terminate the Plan at any time, it is anticipated that all future Plan Years will be 12 Month Plan Years. During the election period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Plan Administrator, which benefit options the Participant wishes to select and purchase with his or her cafeteria plan benefit dollars. Any such election shall be effective for any benefit expenses incurred during the Plan Year which follows the end of the election period. With regard to subsequent annual elections, the following options shall apply:

- a. A Participant or individual who failed to initially elect to participate may elect different or new benefits under the Plan during the election period;
- b. A Participant may terminate participation in the Plan by notifying the Plan Administrator in writing during the election period that the Participant does not want to participate in the Plan for the next Plan Year, or by not electing any benefit options;
- c. An individual who elects not to participate for the Plan Year following the election period will have to wait until the next election period before again electing to participate in the Plan, except as provided for in the Change of Elections section.

### **C. Failure to Elect**

Any individual failing to complete an election of benefits form by the end of the applicable election period shall be deemed to have elected not to participate in the Plan for the upcoming 12 Month Plan Year. Thus, no further salary redirections shall therefore be authorized for such 12 Month Plan Year.

#### **D. Change of Elections**

- a. Any Participant may change a benefit election after the 12 Month Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such 12 Month Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under the applicable regulations adopted by the Department of the Treasury, the provisions of which are incorporated herein by reference. Notwithstanding anything herein to the contrary, if the regulations conflict with the terms of this Plan, then such regulations shall control.

In general, a change in election is not consistent if the change in status is the result of a Participant's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, spouse or dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's spouse, or dependent becomes eligible for continuation coverage under the Pool's group health plan as provided in 26 U.S.C. Section 4980B or any similar state law, then the Participant may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility and continuation due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Plan Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by the applicable Treasury regulations:

- 1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment;
- 2) Number of dependents: Events that change a Participant's number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- 3) Employment Status: Any of the following events that change the employment status of the Participant, spouse, or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Participant, spouse, or dependent rely on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;
- 4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and
- 5) Residency: A change in the place of residence of the Participant, spouse or dependent.

For the Dependent Care Assistance Program, a dependent becoming or ceasing to be a "qualifying dependent" as defined under 26 U.S.C. Section 21(b) shall also qualify as a change in status.

- b. Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a 12 Month Plan Year and make a new election that corresponds with the special enrollment rights provided in 26 U.S.C. Section 9801(f). Such change shall take place on a prospective basis.
- c. Notwithstanding subsection (a), in the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a dependent of the Participant):
  - 1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or
  - 2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former spouse or other individual to provide coverage for such child, under that individual's plan and such coverage is actually provided.
- d. Notwithstanding subsection (a), a Participant may change elections to cancel or reduce accident or health coverage for the Participant or the Participant's spouse or dependent if the Participant or the Participant's spouse or dependent is enrolled in the accident or health coverage of the Pool and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the 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 Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's spouse or dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect to commence or increase coverage under the Plan if a benefit package option under the Plan provides similar coverage.
- e. If the cost of a qualified benefit plan increases or decreases during a 12 Month Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the salary redirections of all affected Participants for such benefit. However, if the cost of a benefit package option increases or decreases significantly, the Plan Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Pool.

If the coverage under a plan is significantly curtailed or ceases during a 12 Month Plan Year, affected Participants may revoke their elections of such benefit and, in lieu thereof, elect to receive on prospective basis coverage under another plan with similar coverage.

If coverage under a plan ceases during the 12 Month Plan Year, affected Participants may revoke their elections of such benefit and in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect

the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options. In addition, those eligible employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's spouse or dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a spouse's, former spouse's or dependent's employer if (a) the cafeteria plan or other benefits plan of the spouse's, former spouse's or dependent's employer permits its Participants to make a change as authorized in 26 C.F.R. Sections 1.125-4(b) through (9); or (b) the cafeteria plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the other cafeteria plan or a qualified benefits plan.

A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A change in election due to a cost change is allowable in the Dependent Care Assistance Program only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a cost or coverage change under this subsection nor may the Health Care Reimbursement Plan election be changed due to the election of a Health Savings Account by the Participant.

- f. With regard to the Health Savings Account Benefit, a Participant who has elected to make elective contributions under such arrangement may modify or revoke the election prospectively, provided such change is consistent with Code Section 223 and the related Treasury regulations.

## **SECTION VI—HEALTH CARE REIMBURSEMENT PLAN**

### **A. Establishment of Plan**

This Health Care Reimbursement Plan is intended to qualify as a medical reimbursement plan under 26 U.S.C. Section 105 and shall be interpreted in a manner consistent with such Code Section and the related Treasury Regulations. Participants who elect to participate in this Health Care Reimbursement Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed under this Health Care Reimbursement Plan shall be periodically paid from amounts allocated to the Health Care Reimbursement Fund. Periodic payments reimbursing Participants from the Health Care Reimbursement Fund shall in no event occur less frequently than monthly.

## **B. Definitions**

For the purposes of this Section and the Cafeteria Plan, the terms below have the following meanings:

- a. "Health Care Reimbursement Fund" means the fund established for Participants pursuant to this Plan to which part of their cafeteria plan benefit dollars may be allocated and from which all allowable Medical Expenses may be reimbursed.
- b. "Health Care Reimbursement Plan" means the plan of benefits contained in this section, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant, spouse or dependents.
- c. "Highly Compensated Participant" means, for the purposes of this section and determining discrimination under 26 U.S.C. Section 105(h), a Participant who is:
  - 1) one of the five (5) highest paid officers;
  - 2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than ten percent (10%) in value of the stock of the employer; or
  - 3) among the highest paid twenty-five percent (25%) of all employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).
- d. "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" as defined in 26 U.S.C. Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury Regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. However, a Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's spouse or individual policies maintained by the Participant or his spouse or dependent. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in 26 U.S.C. Section 7702B(c).
- e. The definitions as found in 26 U.S.C. Section 213(d) are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Plan.
- f. "12 Month Plan Year" means the Plan Year from July 1<sup>st</sup> of each year and ends on June 30<sup>th</sup> of the following year as determined and adopted by the Plan Trustees.

## **C. Forfeitures**

The amount in the Health Care Reimbursement Fund as of the end of any 12 Month Plan Year (and after the processing of all claims for such 12 Month Plan Year) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to the Application of Benefit Plan Surplus section.

## **D. Limitation on Allocations**

Notwithstanding any provision contained in this Health Care Reimbursement Plan to the contrary, the most that a Participant can contribute to your Health Care Reimbursement Plan each 12 Month Plan Year is \$2,400.

**E. Nondiscrimination Requirements**

- a. It is the intent of this Health Care Reimbursement Plan not to discriminate in violation of the Internal Revenue Code and the Treasury Regulations adopted thereunder.
- b. If the Plan Administrator deems it necessary to avoid discrimination under this Health Care Reimbursement Plan, it may, but shall not be required to, reject any elections or reduce contributions or benefits in order to assure compliance with this section. Any act taken by the Plan Administrator under this section shall be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any elections or reduce contributions or benefits, it shall be done in the following manner. First, the benefits designated for the Health Care Reimbursement Fund by the member of the group in whose favor discrimination may not occur pursuant to 26 U.S.C. Section 105 that elected to contribute the highest amount to the fund for the 12 Month Plan Year shall be reduced until the nondiscrimination tests set forth in this section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to 26 U.S.C. Section 105 who has elected the second highest contribution to the Health Care Reimbursement Fund for the 12 Month Plan Year. This process shall continue until the nondiscrimination tests set forth in this section or the Internal Revenue Code are satisfied. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

**F. Coordination with Cafeteria Plan**

All Participants under the Cafeteria Plan are eligible to receive benefits under this Health Care Reimbursement Plan if they elect to participate. Other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

**G. Health Care Reimbursement Plan Claims**

- a. All Medical Expenses incurred during the 12 Month Plan Year by a Participant, spouse or dependent shall be reimbursed during the 12 Month Plan Year, even though the submission of such a claim occurs after his participation hereunder ceases; provided that the Medical Expenses were incurred during the applicable 12 Month Plan Year and are submitted within ninety (90) days of the date participation ceases. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.
- b. The Plan Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Reimbursement Fund for the 12 Month Plan Year. Reimbursements shall be made available to the Participant throughout the 12 Month Plan Year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his spouse or dependents.
- c. Claims for the reimbursement of Medical Expenses incurred in any 12 Month Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however,

that if a Participant fails to submit a claim within the ninety (90) day period immediately following the end of the 12 Month Plan Year, those Medical Expense claims shall be denied by the Plan Administrator.

- d. Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Plan Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Plan Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Reimbursement Fund, such amount will not be claimed as a tax deduction. The Plan Administrator shall retain a file of all such payment/reimbursement applications.

## **SECTION VII—DEPENDENT CARE ASSISTANCE PROGRAM**

### **A. Establishment of Program**

This Dependent Care Assistance Program is intended to qualify as a program under 26 U.S.C. Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed under this Dependent Care Assistance Program shall be paid from amounts allocated to the Participant's Dependent Care Assistance Account.

**FEDERAL TAX LAWS PERMIT A TAX CREDIT FOR CERTAIN DEPENDENT CARE EXPENSES FOR WHICH A PARTICIPANT MAY BE PAYING IF HE OR SHE IS NOT A PARTICIPANT IN THIS PLAN. A PARTICIPANT MAY SAVE MORE MONEY BY TAKING ADVANTAGE OF THIS TAX CREDIT RATHER THAN USING THE DEPENDENT CARE ASSISTANCE ACCOUNT UNDER THIS PLAN.**

### **B. Definitions**

For the purposes of this Section and the Cafeteria Plan the terms below shall have the following meanings:

- a. "Dependent Care Assistance Account" means the account established for a Participant pursuant to this section to which part of his cafeteria plan benefit dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed.
- b. "Dependent Care Assistance Program" means the program of benefits contained in this section, which provides for the reimbursement of eligible expenses for the care of the qualifying dependents of Participants.
- c. "Earned Income" means earned income as defined under 26 U.S.C. Section 32(c)(2), but excluding such amounts paid or incurred by the employer for dependent care assistance to the Participant.
- d. "Employment-Related Dependent Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under 26 U.S.C. Section 21(b)(2). Generally, they shall include expenses for

household services and for the care of a qualifying dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more qualifying dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's qualifying dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

- 1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses if incurred for a dependent of the Participant who has not attained the age of thirteen (13) or a Qualifying individual who regularly spends at least eight (8) hours per day in the Participant's household;
  - 2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any;
  - 3) If the expense is incurred at an educational institution for pre-school children, only expenses for non-school care are eligible for older children; and
  - 4) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of nineteen (19) or to an individual who is a tax deductible dependent of such Participant or such Participant's spouse.
- e. "Qualifying Dependent" means, for Dependent Care Assistance Program purposes,
- 1) a dependent of a Participant who is under the age of thirteen (13),
  - 2) a dependent or the spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal abode of the Participant for more than one-half of such taxable year; or
  - 3) a child that is deemed to be a Qualifying dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to 26 U.S.C. Section 21(e)(5).
  - 4) An eligible dependent is someone for whom a Participant can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses."
- f. The definitions as found in 26 U.S.C. Section 213(d) are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Assistance Program.
- g. "12 Month Plan Year" means the Plan Year from July 1<sup>st</sup> of each year and ends on June 30<sup>th</sup> of the following year as determined and adopted by the Plan Trustees.

### **C. Dependent Care Assistance Accounts**

The Plan Administrator shall establish a Dependent Care Assistance Account for each Participant who elects to apply cafeteria plan benefit dollars to Dependent Care Assistance Program benefits.

#### **D. Increases in Dependent Care Assistance Accounts**

A Participant's Dependent Care Assistance Account shall be increased each pay period by the portion of cafeteria plan benefit dollars that Participant has elected to apply toward his or her Dependent Care Assistance Account pursuant to elections made under the Participant Elections section hereof.

#### **E. Decreases in Dependent Care Assistance Accounts**

A Participant's Dependent Care Assistance Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant. See subsection L below for claim submission information.

#### **F. Allowable Dependent Care Assistance Reimbursement**

Subject to limitations contained in this Program, and to the extent of the amount contained in the Participant's Dependent Care Assistance Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the employer full reimbursement for the entire amount of such expenses incurred during the 12 Month Plan Year or portion thereof during which he or she is a Participant.

#### **G. Periodic Statements of Benefits**

The plan administrator will provide you with a statement of your account during the fourth quarter of the plan year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the plan year.

#### **H. Forfeitures**

The amount in a Participant's Dependent Care Assistance Account as of the end of any 12 Month Plan Year (and after the processing of all timely submitted claims for such 12 Month Plan Year) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

#### **I. Limitation on Payments**

Notwithstanding any provision contained in this section to the contrary, amounts paid from a Participant's Dependent Care Assistance Account in or on account of any taxable year of the Participant shall not exceed the lesser of the earned income limitation described in 26 U.S.C. Section 129(b) or \$5,000 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of 26 U.S.C. Section 21(e)).

The law places limits on the amount of money that can be paid in a calendar year from a Participant's Dependent Care Assistance Account. Generally, reimbursements may not exceed the lesser of:

- 1) \$5,000 (if Participant is married filing a joint return or head of a household) or \$2,500 (if Participant is married filing separate returns);
- 2) Participant's taxable compensation;

- 3) Participant's spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

#### **J. Nondiscrimination Requirements**

- a. It is the intent of this Dependent Care Assistance Program that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under 26 U.S.C. Section 129(d).
- b. It is the intent of this Dependent Care Assistance Program that not more than twelve and one-half percent (12.5%) of the amounts paid by the participating employer for dependent care assistance during the Short Plan Year will be provided for the class of individuals who are shareholders or owners (or their spouses or dependents), each of whom (on any day of the Plan Year) owns more than five percent (5%) of the stock or of the capital or profits interest in the employer.
- c. If the Plan Administrator deems it necessary to avoid discrimination or possible taxation to a group of Participants in whose favor discrimination may not occur in violation of 26 U.S.C. Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this section. Any act taken by the Plan Administrator under this section shall be carried out in a uniform and nondiscriminatory manner. If the Plan Administrator decides to reject any elections or reduce contributions or benefits, it shall be done in the following manner. First, the benefits designated for the Dependent Care Assistance Account by the affected Participant that elected to contribute the highest amount to such account for the 12 Month Plan Year shall be reduced until the nondiscrimination tests set forth in this section are satisfied, or until the amount designated for that Participant's account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Assistance Account for the 12 Month Plan Year. This process shall continue until the nondiscrimination tests set forth in this section are satisfied. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

#### **K. Coordination with Cafeteria Plan**

All Participants under the Cafeteria Plan are eligible to receive benefits under this Dependent Care Assistance Program if they make an election to participate in this benefit. Other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

#### **L. Dependent Care Assistance Program Claims**

The Plan Administrator shall direct the payment of all such Dependent Care Assistance claims to the Participant upon the presentation to the Plan Administrator of documentation of such expenses in a form satisfactory to the Plan Administrator. However, in the Plan Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Plan Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred and the amount of such expense. In addition, the Plan Administrator may

require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- a. The dependent or dependents for whom the services were performed;
- b. The nature of the services performed for the Participant.
- c. The cost of the services;
- d. The name, address, and in most cases, the taxpayer identification number of the service provider;
- e. The relationship, if any, of the person performing the services to the Participant;
- f. If the services are being performed by a child of the Participant, the age of the child;
- g. A statement as to where the services were performed;
- h. If any of the services were performed outside the home, a statement as to whether the dependent for whom such services were performed spends at least eight (8) hours a day in the Participant's household;
- i. If the services were being performed in a day care center, a statement:
  - 1) that the day care center complies with all applicable laws and regulations of the state of residence,
  - 2) that the day care center provides care for more than six (6) individuals (other than individuals residing at the center), and
  - 3) about the amount of fee paid to the provider.
- j. If the Participant is married, a statement containing the following:
  - 1) the spouse's salary or wages if he or she is employed, or
  - 2) if the Participant's spouse is not employed, that
    - a) he or she is incapacitated, or
    - b) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.
- k. If a Participant fails to submit a claim within the ninety (90) day period immediately following the end of the 12 Month Plan Year, those claims shall be denied by the Plan Administrator.

## **SECTION VIII—BENEFITS AND RIGHTS**

### **A. Claim for Benefits**

- a. Any claim for Benefits shall be made to the Plan Administrator.
- b. This Plan maintains a single appeals process for Dependant Care Assistance Program Benefits, and a 2 level appeals process for Health Care Reimbursement Plan and Health Savings Account Benefits. Appeals must be in writing to the Plan Administrator whose address is listed in Section XV of this document. You will be provided with:

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- in deciding an appeal of any adverse benefit determination Health Care Reimbursement Plan or Health Savings Account Benefits a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination Health Care Reimbursement Plan or Health Savings Account Benefits that is based in whole or in part on a medical judgment, the Plan Administrator or its designee will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

If still dissatisfied with the initial appeal level determination of Health Care Reimbursement Plan or Health Savings Account Benefits you will have 90 calendar days from receipt of the first level review determination to request a second level appeal review by writing to the Plan Administrator whose address is listed in Section XV of this document. The Plan will make an appeal determination according to the following timeframes:

- **If an appeal is filed with the Plan more than 30 days before the next Board meeting,** the review will occur at the next Board meeting date.
- **If an appeal is filed with the Plan within 30 days of the next Board meeting,** the Board review will occur no later than the second meeting following receipt of the appeal.
- If special circumstances (such as the need to hold a hearing) require a further extension of time, the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
- After the Board makes its decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.
- You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.

There is no second level of appeal for an adverse benefit determination for Dependant Care Assistance Program Benefits. If a Health Care Reimbursement Plan or Health Savings Account Benefits determination is adverse, a notice of appeal determination will be provided and it will include at each level of the appeal review:

- the specific reason(s) for the adverse appeal review decision;
- reference the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- for certain applicable employers participating in VVEBP, contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal; and
- in the notice of first level appeal review determination, the notice will describe the process to proceed to a second level appeal review and timeframes if still dissatisfied with the determination. If still dissatisfied with the initial appeal level determination you will have 90 calendar days from receipt of the first level review determination to request a second level appeal review by writing to the Plan Administrator whose address is listed in Section XV of this document.

There is no extension permitted in the first or second level of the appeal review process.

This concludes the appeals process under this Plan. This Plan does not offer a voluntary appeal process.

- c. Any balance remaining in the Participant's Dependent Care Assistance Program or Health Care Reimbursement Plan as of the end of the 12 Month Plan Year and each subsequent Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer, unless the Participant had made a claim for such 12 Month Plan Year or Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the 12 Month Plan Year or Plan Year shall be forfeited and credited to the benefit plan surplus.

#### **B. Application of Benefit Plan Surplus**

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the 12 Month Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent 12 Month Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall first be used to defray any administrative costs and experience losses and thereafter be retained by the Plan.

## **SECTION IX—ADMINISTRATION**

### **A. Plan Administration**

The operation of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of those entitled to participate in the Plan. The Plan Administrator shall have full power and sole discretion to administer and interpret the Plan in all of its details, subject, however, to the pertinent provisions of the Internal Revenue Code and related regulations. The Plan Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

- a. To make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plan;
- b. To interpret the Plan, the Plan Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- d. To reject elections or to limit contributions or benefits for certain highly compensated Participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Internal Revenue Code;
- e. To provide Participants with a reasonable notification of their benefits available by operation of the Plan;
- f. To provide Participants with statements of their accounts periodically during the 12 Month Plan Year, showing their account balances;
- g. To process reimbursement requests and to authorize the payment of benefits; and
- h. To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Plan Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of 26 U.S.C. Section 125 and the Treasury Regulations there under.

### **B. Examination of Records**

The Plan Administrator shall make available to each Participant, such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

### **C. Payment of Expenses**

Any reasonable administrative expenses shall be paid by participating employers unless the participating employers determine that administrative costs shall be borne by the Participants under the Plan or by the Pool. The Plan Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

**D. Indemnification of Plan Administrator**

The participating employers agree to indemnify and to defend to the fullest extent permitted by law any individual serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any employee or former employee who previously served as Plan Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

**SECTION X—AMENDMENT OR TERMINATION OF PLAN**

**A. Amendment**

The Plan Trustees, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

**B. Termination**

The Plan Trustees are establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Plan Trustees reserve the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. No further additions shall be made to the Health Care Reimbursement Fund or Dependent Care Assistance Account, but all payments from such fund shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims). Any amounts remaining in any such fund or account as of the end of the Plan Year in which Plan termination occurs shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

**SECTION XI—CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered by health benefits coverage under this Plan will be entitled to elect a temporary continuation of health coverage (called "COBRA continuation coverage"). This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended simply to reflect the current state of the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Care Reimbursement Plan.

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of 26 U.S.C. Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in 26 U.S.C. Section 4980B.

#### **A. Description of COBRA Continuation Coverage**

COBRA continuation coverage is the temporary continuation of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of certain events that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

#### **B. Qualified Beneficiaries**

In general, a Qualified Beneficiary can be:

- a. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- b. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services as an employee for the employer sponsoring the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

### **C. Qualifying Events**

A Qualifying Event is any of the following if the Plan provides that the Plan Participant will lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- a. The death of a covered Employee.
- b. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- c. The divorce or legal separation of a covered Employee from the Employee's Spouse.
- d. A covered Employee's entitlement to benefits under the Medicare program.
- e. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependents under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the Covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within twelve (12) months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a Covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the Covered Employee and eligible dependents may be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

### **D. Procedure for Obtaining COBRA Continuation Coverage**

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

If Timely Payment (payment within the time period required by the Plan) is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid may be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is thirty (30) days after

the notice is provided by the Plan to the Qualified Beneficiary. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount. Failure of the Qualified Beneficiary to pay a shortfall in the Timely Payment within the thirty (30) day period identified above, may result in termination of COBRA continuation coverage.

#### **E. Election Period**

The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for the employee and certain family members, but only within a limited period of sixty (60) days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

#### **F. Informing the Plan Administrator of the Occurrence of a Qualifying Event**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within thirty (30) days following the date coverage ends when the Qualifying Event is:

- a. the end of employment or reduction of hours of employment,
- b. death of the employee,
- c. commencement of a proceeding in bankruptcy with respect to the employer, or
- d. enrollment of the employee in any part of Medicare,

#### **IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within sixty (60) days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the sixty (60) day notice period, a spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this written notice to the Plan Administrator.**

**NOTICE PROCEDURES:**

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Verde Valley Employee Benefit Pool (VVEBP)  
ATTN: COBRA Qualifying Event  
4041 N. Central Ave., Ste. 1200  
Phoenix, Arizona 85012

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension. If you have received a determination of disability from the Social Security Administration, please contact the Plan Administrator for more information about possible COBRA extension periods.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Notice may be provided for all Qualified Beneficiaries at the last known address for the employee. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

**G. Notice of Unavailability of COBRA Continuation Coverage**

If the Plan Administrator receives notice of a Qualifying Event from a Qualified Beneficiary and determines that the individual is not entitled to COBRA continuation coverage, the Plan Administrator or its designee will provide to such individual an explanation as to why the individual is not entitled to COBRA continuation coverage. The notice will be provided within the same time frame that the Plan Administrator or its designee would have provided the notice of the right to elect COBRA continuation coverage.

**H. Waiver of Qualified Beneficiary's Election Rights**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the COBRA election period. Revocation of the waiver is then an automatic election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee.

## **I. Termination of COBRA Continuation Coverage**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- a. The last day of the applicable maximum coverage period.
- b. The last day for which payment is made to the Plan for COBRA continuation of coverage with respect to the Qualified Beneficiary.
- c. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- d. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- e. The date, after the date of the election, that the Qualified Beneficiary is first entitled to enroll in the Medicare program (either part A or part B, whichever occurs earlier).
- f. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - 1) (i) twenty-nine (29) months after the date of the Qualifying Event if the Qualified Beneficiary is determined to be disabled during the first sixty (60) days of continuation coverage and the Qualified Beneficiary has provided notice of such determination within the first eighteen (18) months of continuation of coverage, or (ii) the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - 2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim or the failure to properly and timely pay for coverage.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to continue to make coverage available to the individual who is not a Qualified Beneficiary.

If COBRA continuation coverage for a Qualified Beneficiary terminates before the expiration of the maximum coverage period, the Plan Administrator or its designee will provide notice to the Qualified Beneficiary of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the determination regarding termination of the COBRA continuation coverage.

## **SECTION XII—MISCELLANEOUS**

### **A. Plan Interpretation**

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. As noted above, the Plan Administrator has full and sole discretion to interpret the provisions of this Plan. Any such interpretation shall be binding upon Participants. This Plan shall be read in its entirety and not severed except as provided in the Severability section.

### **B. Gender and Number**

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

### **C. Written Document**

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of 26 U.S.C. Section 125, 129 and any related Treasury Regulations for cafeteria plans.

### **D. Exclusive Benefit**

This Plan shall be maintained for the exclusive benefit of the individuals who participate in the Plan.

### **E. Participant's Rights**

This Plan shall not be deemed to constitute an employment contract between the participating employers and any Participant(s) or to be a consideration or an inducement for the employment of any Participant or employee. Nothing contained in this Plan shall be deemed to give any Participant or employee the right to be retained in the service of any participating employer or to interfere with the right of any participating employer to discharge any Participant or employee at any time regardless of the effect which such discharge shall have upon him or her as a Participant of this Plan.

### **F. Action by the Employer**

Whenever any participating employer or Pool under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

### **G. No Guarantee of Tax Consequences**

Neither the Plan Administrator, the Plan, the Pool nor the participating employers make any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state 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 excludable from the Participant's gross

income for federal and state income tax purposes, and to notify the Plan if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

#### **H. Indemnification of Employer by Participants**

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted benefit, such Participant shall indemnify and reimburse the employer and/or the Plan for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

#### **I. Funding**

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific benefit, but may instead be considered general assets of the employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Plan, the Pool, employers or the Plan Administrator to maintain any fund or 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 employer from which any payment under the Plan may be made.

#### **J. Governing Law**

This Plan is governed by the Internal Revenue Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Plan, the Pool or any employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Arizona.

#### **K. Severability**

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

#### **L. 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 affect the Plan or the construction of any provision thereof.

### **M. Family and Medical Leave Act**

If a Participant takes leave under the Family and Medical Leave Act, existing elections for the Health Care Reimbursement Plan may be revoked or changed. If coverage in these benefits terminates due to revocation of the benefit while the Participant is on leave or due to non-payment of contributions, the Participant will be permitted to reinstate coverage for the remaining part of the Short Plan Year or Plan Year upon his or her return. For the Health Care Reimbursement Plan, a Participant may continue coverage or may revoke coverage and resume it when the Participant returns. A Participant can resume coverage at its original level and make payments for the time the Participant is on leave. For example, if a Participant elects \$1,200 for the year and is out on leave for 3 months, then returns and elects to resume coverage at that level, the remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively the maximum amount will be reduced proportionately for the time that the Participant was gone. For example, if the Participant elects \$1,200 for the year and is out on leave for 3 months, the amount will be reduced to \$900. The expenses incurred during the time the Participant is not in the Health Care Reimbursement Plan are not reimbursable.

If coverage is continued during unpaid leave, the Participant may pre-pay for the coverage, may pay for coverage on an after-tax basis while on leave, or the Employer may arrange a schedule for payments when the Participant returns. Questions about the FMLA and its application to the Plan should be directed to the Plan Administrator.

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with 26 C.F.R. Section 1.125-3.

### **N. Uniform Services Employment and Reemployment Rights Act (USERRA)**

If a Participant is going into or returning from military service, the Participant may have special rights to health care coverage under your Health Care Reimbursement Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. The Plan Administrator for further details regarding these rights.

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

## **SECTION XIII—PROVISION OF PROTECTED HEALTH INFORMATION TO THE PLAN SPONSOR**

This section is intended to bring the Verde Valley Employee Benefit Pool (VVEBP) Flexible Benefits Plan (the "Plan") into compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the "HIPAA Privacy Rule" and/or "HIPAA Security Rule" as applicable) by establishing the conditions under which the plan sponsor will receive, use and/or disclose Protected Health Information. Provisions related to the HIPAA Security Rule do not apply until the effective date of the HIPAA Security Rule for the Plan.

## **A. Definitions**

All terms defined in the HIPAA Privacy Rule and the HIPAA Security Rule shall have the same meaning set forth therein. For purposes of this document, the definition of Protected Health Information under the HIPAA Privacy Rule and HIPAA Security Rule generally means:

Information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

## **B. Permitted Disclosures of Protected Health Information to the Plan Sponsor**

Subject to the conditions of Paragraphs C and D, the Plan (and any health insurance issuer or business associate acting on behalf of the Plan) may disclose individuals' Protected Health Information to the plan sponsor for the plan sponsor to carry out plan administration functions performed by the plan sponsor. The Plan (and any health insurance issuer or business associate acting on behalf of the Plan) may not disclose individuals' Protected Health Information to the plan sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

## **C. No Disclosure of Protected Health Information to the Plan Sponsor Without Certification by Plan Sponsor**

Except as provided below in Paragraph E with respect to the Plan's disclosure of summary health information and enrollment/disenrollment information, the Plan will not disclose Protected Health Information to the plan sponsor unless the plan sponsor certifies that:

- a. the Plan has been amended to incorporate the provisions of Paragraph D (the requirements of 45 CFR Section 164.504(f)(2)(ii)); and
- b. the plan sponsor agrees to comply with the provisions of Paragraph D.

## **D. Conditions of Disclosure of Protected Health Information to the Plan Sponsor**

The plan sponsor agrees to the following restrictions and conditions of receiving Protected Health Information (other than summary health information or enrollment/disenrollment information as explained in Paragraph E below). The plan sponsor shall:

- a. Not use or further disclose the Protected Health Information other than as permitted or required herein or as required by law.
- b. Ensure that any agent(s), including a subcontractor, to whom it provides Protected Health Information received from the Plan agrees to the same restrictions and conditions that apply to the plan sponsor with respect to such Protected Health Information.
- c. Not use or disclose Protected Health Information 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 Protected Health Information that is inconsistent with the uses or disclosures provided for of which the plan sponsor becomes aware.

- e. Make available Protected Health Information to comply with an individual's right to access Protected Health Information in accordance with 45 C.F.R. Section 164.524.
- f. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. Section 164.526.
- g. Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528.
- h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.
- i. If feasible, return or destroy all Protected Health Information 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, the plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- j. Ensure that the required adequate separation, described in Paragraph F below, is established and maintained.

The plan sponsor further agrees that if it creates, receives, maintains, or transmits any electronic Protected Health Information (other than enrollment/disenrollment information and summary health information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information, and it will ensure that any agents (including subcontractors) to whom it provides such electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect the information. Plan sponsor will report to the Plan any security incident of which it becomes aware.

**E. Disclosures of Summary Health Information and Enrollment/Disenrollment Information to the Plan Sponsor**

- a. The Plan (or a health insurance issuer with respect to the Plan) may disclose summary health information to the plan sponsor without the need to comply with the conditions and restrictions of Paragraphs C and D, if the plan sponsor requests the summary health information for the purpose of:
  - 1) Obtaining premium bids from health plans (including health insurance issuers) for providing health insurance coverage under the Plan; or
  - 2) Modifying, amending, or terminating the Plan.
- b. The Plan (or a health insurance issuer with respect to the Plan) may disclose information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan without the need to comply with the conditions and restrictions of Paragraphs C and D.

**F. Required Separation between the Plan and the Plan Sponsor**

- a. The following classes of employees or other persons under the control of the plan sponsor will have access to Protected Health Information received from the Plan (or from a health insurance issuer with respect to the Plan):
  - 1) Benefits Personnel
  - 2) Accounting/Financial Personnel
  - 3) IT Personnel
  - 4) Quality Assurance/Audit Personnel
  - 5) Senior Management
- b. No other persons shall have access to Protected Health Information. The listed classes of employees or other persons under the control of the plan sponsor will have access to Protected Health Information solely to perform the plan administration functions that the plan sponsor performs for the Plan. They will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the plan sponsor) for any use or disclosure of Protected Health Information in violation of the provisions of this section. The plan sponsor will ensure that the provisions of this Paragraph F are supported by reasonable and appropriate security measures to the extent that the classes or employees or other persons have access to electronic Protected Health Information.

**SECTION XIV—DEFINITIONS**

**Affiliated Employer**

The employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the employer; and any other entity required to be aggregated with the employer pursuant to Treasury regulations under Code Section 414(o).

**Benefit**

Any of the optional benefit choices available to a Participant as outlined in the Benefits section.

**Cafeteria Plan Benefit Dollars**

The amount available to Participants, pursuant to the Contributions to the Plan section, to purchase benefits. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

**Compensation**

The amounts received by the Participant from the employer during the 12 Month Plan Year.

**Dependent**

Any individual who qualifies as a dependent under 26 U.S.C. Section 152 (as modified by Code Section 105(b)).

**Effective Date**

July 1, 2008.

**Election Period**

The thirty (30) day period immediately preceding the beginning of the 12 Month Plan Year. However, an individual's initial election period shall be determined pursuant to the Participant Elections section.

**Eligible Employee**

Any employee who has satisfied the provisions of the Eligibility section. An individual shall not be an eligible employee if such individual is not reported on the payroll records of the employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the employer on its payroll records are not eligible employees and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

**Employee**

Any person who is employed by the employer. The term employee shall include leased employees within the meaning of 26 U.S.C. Section 414(n)(2).

**ERISA**

The Employee Retirement Income Security Act of 1974, as amended from time to time.

**Health Care Professional**

A person who is not the Participant or the parent, Spouse, sibling (by birth or marriage) or child of the Participant, who is licensed, accredited or certified to perform specified health services consistent with State law, and acts within the scope of his or her license as either: (i) a Medical Doctor (MD) or Doctor of Osteopathy (DO) authorized to practice medicine, to perform surgery; (ii) behavioral health practitioner; (iii) chiropractor; (iv) dental hygienist; (v) dentist; (vi) nurse; (vii) nurse practitioner; (viii) physician assistant; (ix) certified nurse midwife; (x) podiatrist; (xi) occupational, physical, respiratory or speech therapist; or (xii) speech pathologist.

**Key Employee**

An employee described in 26 U.S.C. Section 416(i)(1) and the Treasury regulations thereunder.

**Participant**

Any eligible individual who elects to become a Participant and has not for any reason become ineligible to participate further in the Plan.

**Participating Employer**

An employer that has elected to participate in the Verde Valley Employee Benefit Pool and make benefits developed and adopted by the Pool available to eligible employees and their dependents.

**Plan Administrator**

The individual(s) or corporation appointed by the participating employer to carry out the administration of the Plan. The participating employer shall be empowered to appoint and remove the Plan Administrator from time to time as it deems necessary for the proper administration of the Plan. In the event the Plan Administrator has not been appointed, or resigns from a prior appointment, the employer shall be deemed to be the Plan Administrator.

**Plan Year**

The twelve (12) month period beginning July 1st and ending June 30th. The Plan Year shall be the coverage period for benefits provided under this Plan. In the event a Participant commences participation during the plan year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

**Pool**

Verde Valley Employee Benefit Pool (VVEBP) and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan.

**Salary Redirection**

The contributions made by the participating employer on behalf of Participants. These contributions shall be converted to cafeteria plan benefit dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Participant Elections.

**Salary Redirection Agreement**

An agreement between the Participant and the participating employer under which the Participant agrees to reduce his compensation or to forego all or part of the increases in such compensation and to have such amounts contributed by the participating employer to the Plan on the Participant's behalf. The salary redirection agreement shall apply only to compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and 26 U.S.C. Section 125 into account) and, subsequently does not become currently available to the Participant.

**Spouse**

The legally married husband or wife of a Participant, unless legally separated by court decree.

## **SECTION XV—GENERAL INFORMATION ABOUT THE PLAN**

This Section contains certain general information which you may need to know about the Plan.

### **A. General Plan Information**

Verde Valley Employee Benefit Pool (VVEBP) Flexible Benefits Plan is the name of the Plan.

The provisions of the Plan become effective on July 1, 2008, which is called the Effective Date of the Plan.

Your Plan's records for the Plan Year commencing July 1, 2008 are maintained on a twelve (12) month basis. This is known as the 12 Month Plan Year. The 12 Month Plan Year begins on July 1<sup>st</sup> of each year and ends on June 30<sup>th</sup> of the following year.

This Section contains certain general information which you may need to know about the Plan.

### **B. Plan Administrator Information**

The name and address of your Plan's Administrator are:

Ashton Tiffany, LLC.  
4041 N. Central Ave., Suite 1200  
Phoenix, AZ 85012  
Phone: 1-800-718-8328  
Fax: 602-257-5117

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

### **C. Service of Legal Process**

The name and address of the Plan's agent for service of legal process are:

Verde Valley Employee Benefit Pool (VVEBP)  
4041 N. Central Ave., Ste. 1200  
Phoenix, Arizona 85012

### **D. Type of Administration**

The type of Administration is [an](#) independent third party administrator.

### **E. Claims Submission**

Claims for expenses should be submitted to:  
AmeriBen/IEC Group  
PO Box 7186  
Boise, ID 83707  
(800) 786-7930

www.ameriben.com

**F. Adoption**

On behalf of participating employers, Verde Valley Employee Benefit Pool (VVEBP) hereby adopts the provisions of this plan, and its duly authorized officer has executed this plan document and summary plan description effective the first day of July, 2008.

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

Date: \_\_\_\_\_

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