TUFTS UNIVERSITY
HEALTH REIMBURSEMENT ARRANGEMENT

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HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

The Plan Sponsor hereby adopts this Health Reimbursement Arrangement (the "Plan") for the purpose of allowing certain former employees of the Plan Sponsor and its participating affiliates to obtain reimbursement of eligible medical expenses incurred by such former employees and their family members. The Plan Sponsor intends the Plan to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended. This Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2). The Plan will be interpreted at all times in a manner consistent with such intent.

ARTICLE I
ADOPTION AGREEMENT

1.1 Name of Plan: Tufts University Health Reimbursement Arrangement.

1.2 Sponsor: Tufts University.

Contact Name: Robbyn Dewar, Benefit Programs and Compliance Director.

Address: 200 Boston Ave, Suite 1600, Medford, MA 02155.

Telephone Number: 617-627-7000.

Tax Identification Number: 04-2103634.

The term "Company" shall mean the Plan Sponsor identified above and the following Affiliates who have also adopted the Plan:

_____

_____

_____

1.3 Plan Administrator (if not the Plan Sponsor): _____.

Address: _____

_____.

Telephone Number: _____.

1.4 Plan Number: 602.

1.5 Effective Date:

(a) ☐ New Plan Effective Date:_____.

(b) ☑ Amendment Effective Date: 01/01/2019. This is an amendment and restatement of a plan originally effective 01/01/2018.

1.6 Eligible Retiree: Eligible Retiree means:

(a) A former employee of the Company who has satisfied the following requirements as of his or her retirement:

(1) ☑ Either (A) Completed 5 Years of benefits-eligible service **AND** Attained age 60 **OR** (B) Age plus benefits-eligible service equals 75 or more.

(2) ☑ Enrolled in Medicare Parts A and B and made a timely election for coverage under the Tufts University Retiree Health Insurance Plan.

(3) ☐ (Specify): _____.

1.7 Dependent:

(a) ☐ A Dependent includes a child (as defined in Code Section 152(f)(1)) of the Eligible Retiree until (1) ☐ the date of, (2) ☐ the end of the month in which occurs, or (3) the end of the calendar year in which occurs, the child's _____th birthday.

(b) ☑ N/A.

1.8 Eligible Dependent: A Spouse/ Domestic Partner is an Eligible Dependent:

(a) ☑ initially only if he or she enrolls within 31 days after the later of (1) the Eligible Retiree's retirement date or (2) the Eligible Dependent's attainment of age 65.

(b) ☑ after the Eligible Retiree dies, an Eligible Dependent may continue to be a Participant with respect to his or her own HRA Account, but the Dependent must not participate in another group health plan sponsored by the Company.

1.9 Health Care Expense Exclusion: Health Care Expenses include any expense that qualifies under Code Section 213(d), except for the following:

(a) ☑ Prescription drug expenses.

(b) ☐ (Specify):_____.

1.10 Benefit Credit:

(a) The following annual amount will be credited on behalf of Participants who are Eligible Retirees:

(1) ☑ Discretionary, to be determined in the sole discretion of the Company each Plan Year

(2) ☐ Fixed Dollar Amount of $_____.

(b) The following amount will be credited on behalf of Participants who are Eligible Dependents:

(1) ☑ Discretionary, to be determined in the sole discretion of the Company each Plan Year.

(2) ☐ Fixed Dollar Amount of $_____ for Dependent Spouses.

(3) ☐ Fixed Dollar Amount of $_____ for Dependents other than Spouses.

(4) ☐ (Specify formula):_____

1.11 Insurance Coverage Exception:

(a) ☑ An Eligible Retiree must obtain an individual health insurance policy offered through Via Benefits during the open enrollment period for the 2018 Plan Year or, if later, within 31 days of the later of (1) the Eligible Retiree's retirement date or (2) the Eligible Retiree's attainment of age 65. An Eligible Retiree may change to another individual health insurance policy offered through Via Benefits in subsequent Plan Years during the open enrollment period designated by the Plan Administrator.

(b) ☑ An Eligible Dependent must obtain an individual health insurance policy offered through Via Benefits during the open enrollment period for the 2018 Plan Year or, if later, within 31 days of the later of (1) the Eligible Retiree's retirement date or (2) the Eligible Dependent's attainment of age 65. An Eligible Dependent may change to another individual health insurance policy offered through Via Benefits in subsequent Plan Years during the open enrollment period designated by the Plan Administrator.

(c) ☐ In lieu of obtaining an individual health insurance policy through Via Benefits, an Eligible Retiree or Dependent may establish that he or she: N/A

(1) ☐ Has health coverage under TRICARE

(2) ☐ Has health coverage under a policy or plan provided by his or her Spouse's employer

(3) ☐ Resides outside the United States

1.12 Account Structure:

(a) ☐ *Combined Account*. Only one HRA Account will be established for all Participants in a single family and all credits for such family members will be credited to such HRA Account.

(b) ☑ *Separate Accounts*. A separate HRA Account will be established for each Participant within a single family.

1.13 Timing of Credit: Benefit Credit specified in Section 1.10 will be credited to HRA Accounts as follows:

(a) ☑ On the first day of each Plan Year

(b) ☑ One time on the Eligible Retiree's or Dependent's enrollment date in the age 65 and over program if he or she first becomes eligible to participate in an HRA Arrangement during the Plan Year.

(c) ☐ On the first day of each calendar quarter (i.e., one-fourth of the annual Benefit Credit specified in Section 1.10 will be credited each quarter).

(d) ☐ On the first day of each calendar month (i.e., one-twelfth of the annual Benefit Credit specified in Section 1.10 will be credited each month).

1.14 Carryover of Accounts. Credits remaining in an HRA Account (after the expiration of the claims run-out period) at the end of a Plan Year shall:

(a) ☐ be forfeited on April 1 of the following Plan Year.

(b) ☑ be carried over to the following Plan Year to reimburse Participants for Health Care Expenses incurred during subsequent Plan Years.

(c) ☐ be carried over to the following Plan Year, up to a limit of $_____.

1.15 Death. Participants who are Eligible Dependents shall continue to receive Benefit Credits after the Eligible Retiree's death:

(a) ☑ Yes

(b) ☐ No

1.16 Transitional Payment for Donut Hole.

(a) Participants who are Eligible Retirees and/or Eligible Dependents shall receive an additional HRA Benefit Credit equal to the Medicare D prescription drug "donut hole" for the Plan Year if their prescription drug expenses exceed the prescription drug limit under Medicare D as described in subsection (b).

(1) ☑ Yes

(2) ☐ No

(b) If subsection (a)(1) is checked, the transitional payment will be made only after the Participant incurs the following qualifying prescription drug expenses for the applicable Plan Year:

(1) ☑ After the Participant has accumulated covered Part D expenses in an amount equal to the prescription drug limit under Medicare D set by CMS for the applicable Plan Year.

(2) ☐ After the Participant has accumulated covered Part D expenses in an amount equal to $ _____ for the applicable Plan Year. The designated dollar amount must be higher than the limit set forth in subsection (b)(1).

(c) If subsection (a)(1) is checked, the transitional payment will be administered pursuant to Section 5.7 based on one of the following options:

(1) ☑ Option One: A one-time contribution equal to the difference between the Catastrophic Coverage Level for the applicable Plan Year set by CMS minus the prescription drug limit under Medicare D for the applicable Plan Year set by CMS (the so-called donut hole) will be made to the Participant's HRA Account for the applicable Plan Year after the Participant has reached the level set forth in (b)(1) or (b)(2).

(2) ☐ Option Two: The benefit will be administered as a pool of benefits for all qualifying Participants as set forth in Section 5.7, and the pool for each applicable Plan Year will be $_____.

(3) ☐ Option Three: Once the Participant has reached the level set forth in (b)(1) or (b)(2), all eligible claims for qualifying prescription drug expenses will be reimbursed for the remainder of the applicable Plan Year with no dollar limit.

1.17 Catastrophic Coverage Reimbursement. If box 1 below is checked, then the Catastrophic Coverage Reimbursement provisions of Section 5.8 will apply.

(1) ☑ Yes

(2) ☐ No

ARTICLE II
DEFINITION OF TERMS

2.1 Definitions. Whenever used in this Plan, the following terms shall have the meanings set forth below.

(a) "Affiliate" means any entity which, with the Plan Sponsor, is a member of a controlled group of corporations, a group of trades or businesses under common control, an affiliated service group, or a group of corporations otherwise required to be aggregated, as provided in Code Sections 414(b), (c), (m), and (o), respectively.

(b) "HRA Account" means the hypothetical account established for a Participant to hold his or her Benefit Credits.

(c) "Benefit Credit" means the amount credited to a Participant's HRA Account for the provision of benefits under the Plan as provided in Section 4.2.

(d) "Claims Administrator" means any entity with which the Plan Sponsor or Plan Administrator has entered into a contract for the purpose of processing claims under the Plan.

(e) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

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

(g) "Company" means the Plan Sponsor designated in Section 1.2 and such of its Affiliates listed in Section 1.2 who have adopted the Plan pursuant to Section 9.2.

(h) "Dependent" means the Spouse of an Eligible Retiree and any individual who is, at the date of the Eligible Retiree's retirement from the Company, a dependent of the Eligible Retiree within the meaning of Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof. If elected in Section 1.7, "Dependent" shall also include a child (as defined in Code Section 152(f)(1)) of the Eligible Retiree through the date specified in Section 1.7. Any child to whom Code Section 152(e) (regarding divorced or separated parents) applies shall be treated as a dependent of both parents for purposes of this definition.

(i) "Effective Date" means the date designated in Section 1.5.

(j) "Eligible Dependent" means any Dependent who has satisfied the requirements of Section 1.8.

(k) "Eligible Retiree" means any former employee of the Company who, as of his or her retirement from the Company, satisfies the eligibility requirements specified by the Plan Sponsor in Section 1.6. In no event, however, shall "Eligible Retiree" include a sole proprietor, partner of a partnership, a shareholder of a Subchapter S corporation owning more than two percent (2%) of the corporation, or any individual not classified by the Company as a retired employee of the Company for this purpose, regardless of whether a court or governmental agency determines the individual to be or to have been a former employee of the Company.

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

(m) "Health Care Expense" means an expense incurred by a Participant or by a Dependent in the Participant's family, for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage and premiums for long-term care insurance coverage. Health Care Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant or the Participant's Dependent, or any expenses excluded in Section 1.9. In addition, and notwithstanding anything herein to the contrary, Health Care Expenses shall not include an expense incurred for a medicine or drug regardless of whether it is a prescribed drug or is insulin. Health Care Expenses are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses. Notwithstanding the above or Section 1.9, the Plan will only pay for or reimburse individual health insurance premiums, if the coverage is purchased through Via Benefits, as determined by the Claims Administrator. The Plan will not pay or reimburse claims for covered Part D prescription drug expenses.

(n) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including its regulations and other guidance promulgated thereunder, as of the applicable time that such regulations and guidance are effective.

(o) "Participant" means any Eligible Retiree or, if the Plan Sponsor has elected to make Benefit Credits under Section 1.10(b), his or her Eligible Dependent, who has satisfied the eligibility requirements of Article III hereof and has not, for any reason, become ineligible to participate in the Plan.

(p) "Plan" means the health reimbursement arrangement named in Section 1.1 and set forth herein, as may be amended from time to time.

(q) "Plan Administrator" means the Plan Sponsor or other entity designated in Section 1.3.

(r) "Plan Sponsor" means the entity named in Section 1.2.

(s) "Plan Year" means, with respect to the initial Plan Year, the period from the Effective Date through the next following December 31. Thereafter, "Plan Year" means the twelve (12)-month period commencing on each January 1.

(t) "PHI" means protected health information as described in 45 C.F.R. § 164.103, and generally includes individually identifiable health information held by or on behalf of the Plan.

(u) "Spouse" means the person who is legally married under any applicable state or foreign law to the Eligible Retiree determined as of the applicable time by the Claims Administrator and/or Plan Administrator.

(v) "Years of Service" means years of service as calculated from the date of credited service maintained in the records of the Plan Administrator.

2.2 Gender and Number. When used in this Plan, the masculine shall include the feminine, the singular shall include the plural, and vice versa.

ARTICLE III
PARTICIPATION

3.1 Agreement to Participate. An Eligible Retiree or, if the Plan Sponsor has elected under Section 1.10 to make Benefit Credits on behalf of the Eligible Retiree's Eligible Dependents, his or her Eligible Dependent, shall become a Participant in this Plan on the date he or she has:

(a) Satisfied the requirements to become an Eligible Retiree or Eligible Dependent, as applicable;

(b) Obtained an individual health insurance policy through Via Benefits or any affiliate or, if elected by the Plan Sponsor under Section 1.11, provided satisfactory evidence to the Plan Administrator or Claims Administrator that he or she satisfies an exception to this requirement; and

(c) Completed any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator or its delegate from time to time.

3.2 Cessation of Participation. A Participant shall cease to be a Participant on the earliest of:

(a) with respect to an Eligible Retiree, the date he or she ceases to be an Eligible Retiree for any reason, including death;

(b) with respect to an Eligible Dependent, the date he or she ceases to be a Dependent for any reason, including death;

(c) with respect to an Eligible Dependent Spouse, the date he or she divorces the Eligible Retiree;

(d) with respect to an Eligible Dependent, the date of the Eligible Retiree's death if the Plan Sponsor elects in Section 1.15 to cease Benefit Credits to such Dependent following the Eligible Retiree's death;

(e) with respect to an Eligible Retiree, the date he or she is rehired as an active employee of the Company or any Affiliate;

(f) the effective date of any Plan amendment that renders him or her ineligible to participate; or

(g) the termination of the Plan.

Reimbursement from the Participant's HRA Account after termination of participation shall be governed by Section 5.3.

ARTICLE IV
FUNDING

4.1 Funding. The benefits provided herein shall be provided by the Company out of its general assets, and no assets shall be segregated or earmarked for the purpose of providing benefits hereunder, nor shall any person have any right, title or claim to such assets prior to their payment hereunder. As such, each HRA Account established pursuant to the Plan shall be a hypothetical account which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant under the terms of the Plan or that are protected from the reach of the Company's creditors. In no event may any benefits under the Plan be funded with Participant contributions.

4.2 Benefit Credits. The Company shall credit HRA Accounts of Participants with the Benefit Credits specified in Section 1.10 at the time or times specified in Section 1.13. If the Plan Sponsor has elected a separate account structure under Section 1.12, the Benefit Credit to be made on behalf of a Participant who is an Eligible Dependent shall be made to such Participant's separate HRA Account. No earnings shall be credited at any time with respect to any HRA Account.

ARTICLE V
BENEFITS

5.1 Provision of Benefits. The Plan will reimburse Participants for Health Care Expenses, up to the unused amount in the Participant's HRA Account. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses incurred after he or she becomes a Participant in the Plan and before his or her participation has ceased. In no event shall

any benefits under this Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Health Care Expenses.

5.2 Amount of Reimbursement. At all times during a Plan Year, a Participant shall be entitled to benefits under this Plan for payment of Health Care Expenses in an amount that does not exceed the balance of his or her HRA Account. Each reimbursement hereunder shall be a deduction to such HRA Account available to pay Health Care Expenses under the Plan.

5.3 Expense Reimbursement Procedure. Reimbursement for Health Care Expenses shall be made in accordance with this Section 5.3.

(a) *Timing:* A Participant desiring to receive reimbursement for Health Care Expenses under this Plan shall submit a written application to the Claims Administrator; provided, however, that if the Plan Sponsor has elected Section 1.14(a) (no carryover), Participants must submit all claims incurred during a Plan Year by March 31 following the end of the Plan Year in order for such claim to be eligible for reimbursement hereunder. Notwithstanding the preceding, upon loss of eligibility as provided in Section 3.2, coverage under the Plan ceases, the Participant shall receive no further Benefit Credits under the Plan, and his or her Health Care Expenses incurred after such date will not be reimbursed hereunder even if Benefit Credits remain in the Participant's HRA Account. The Participant may submit claims for reimbursement for Health Care Expenses incurred prior to his or her loss of eligibility, provided the Participant files such claims within one hundred eighty (180) days following such loss of eligibility.

(b) *Claims Substantiation:* The Plan Administrator may require the Participant to furnish a bill, receipt, cancelled check, or other written evidence or certification of payment or of obligation to pay Health Care Expenses. The Claims Administrator will reimburse the Participant from the general assets of the Company for expenses that it determines are Health Care Expenses up to the balance in the Participant's HRA Account at such intervals as the Plan Administrator may deem appropriate (but not less frequently than quarterly). The Plan Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement. Unless a Health Care Expense satisfies the Claims Administrator's procedures for automatic substantiation pursuant to the requirements of Code Section 213(d), each request for reimbursement shall include the following information:

(1) the amount of the Health Care Expense for which reimbursement is requested;

(2) the date the Health Care Expense was incurred;

(3) a brief description and the purpose of the Health Care Expense;

(4) the name of the person for whom the Health Care Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant;

(5) the name of the person, organization or other health care provider to whom the Health Care Expense was or is to be paid;

(6) a statement that the Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Health Care Expense under Code Section 213; and

(7) A written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Participant or his or her Dependents are enrolled must be submitted first to all appropriate claims administrators for such plans before submitting the expenses to the Claims Administrator for reimbursement under the Plan. A Participant who is entitled to payment or reimbursement under a health care flexible spending account in a cafeteria plan under Code Section 125 must receive his or her maximum annual reimbursement under the health care flexible spending account in the cafeteria plan before he or she is entitled to any reimbursement under this Plan.

Claims will be charged to the HRA Account of the Participant who submits the claim. The Plan Administrator may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

(c) *Timing*: The Claims Administrator shall review such claim and respond thereto within thirty (30) days after receiving the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify the claimant within the initial thirty (30)-day period that the Claims Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Claims Administrator. The claimant will have no less than forty-five (45) days from the date he or she receives the notice to provide the requested information. The Claims Administrator shall provide to every claimant who is denied a claim for benefits (in whole or in part) written or electronic notice setting forth in a manner calculated to be understood by the claimant:

(1) the specific reason or reasons for the denial;

(2) specific reference to pertinent plan provisions on which denial is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and

(5) a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

(d) *Claims Denied*: Claims that are partially or wholly denied may be appealed to the Plan Administrator as provided in Section 7.7.

(e) *Simplified Reimbursement Process*. The Claims Administrator may establish a simplified reimbursement process for the payment of health insurance premiums through Via Benefits. Such procedures may involve the direct payment of the health insurance premium from the Participant's HRA Account to the carrier. Such process will be considered to be a reimbursement from the Participant's HRA Account and will be structured to satisfy the requirements for a reimbursement as set forth in this Section.

(f) *Mode of Reimbursement*. The Claims Administrator shall determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

(g) *Forfeiture of Unclaimed Reimbursements.* Any HRA Account payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) shall automatically forfeit twelve (12) months after the check was mailed or the payment was otherwise attempted.

5.4 Carryover of Accounts. To the extent a Participant has a balance in his or her HRA Account at the end of a Plan Year, the balance shall be carried over to following Plan Years to the extent elected by the Plan Sponsor in Section 1.14.

5.5 Death.

(a) *Combined Account*.

(1) In the event the Plan Sponsor elects a combined account structure in Section 1.12, and the Eligible Retiree dies with no Eligible Dependents who are Participants, his or her HRA Account shall be immediately forfeited upon his or her death; provided, however, that his or her estate or representatives may submit claims for Health Care Expenses incurred by the Eligible

Retiree and his or her Dependents prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death.

(2) In the event the Plan Sponsor elects a combined account structure in Section 1.12, and the Eligible Retiree dies with one or more Eligible Dependents who are Participants, his or her HRA Account shall continue and such Participants may continue to submit Health Care Expenses for reimbursement in the normal course if, as elected by the Plan Sponsor in Section 1.15, the surviving Eligible Dependent Participants remain entitled to receive Benefit Credits to the HRA Account after the Eligible Retiree's death. If the Eligible Dependent Participants are not entitled to continue to receive Benefit Credits to the HRA Account after the Eligible Retiree's death, as elected by the Plan Sponsor in Section 1.15, the HRA Account shall be immediately forfeited upon the Eligible Retiree's death; provided, however, that his or her estate or representatives may submit claims for Health Care Expenses incurred by the Eligible Retiree and his or her Dependents prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death.

(3) In the event the Plan Sponsor elects a combined account structure in Section 1.12, and an Eligible Dependent who is also a Participant dies, the HRA Account shall continue, but no further Benefit Credits shall be made to the HRA Account on behalf of the deceased Participant.

(b) *Separate Accounts.*

(1) In the event the Plan Sponsor elects a separate account structure in Section 1.12, and the Eligible Retiree dies, the HRA Account of the Eligible Retiree is immediately forfeited; provided, however, that his or her estate or representatives may submit claims for Health Care Expenses incurred by the Eligible Retiree prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death. If the Eligible Dependents of the Eligible Retiree who are also Participants are not entitled to continue to receive Benefit Credits to their HRA Accounts after the Eligible Retiree's death, as elected by the Plan Sponsor in Section 1.15, then the HRA Accounts of such Participants shall also be forfeited upon the Eligible Retiree's death; provided, however, that the Eligible Dependent Participants may submit claims for Health Care Expenses incurred by the Eligible Retiree and his or her Dependents prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death.

(2) In the event the Plan Sponsor elects a separate account structure in Section 1.12, and an Eligible Dependent who is also a Participant dies, his or her

HRA Account shall be immediately forfeited; provided, however, that his or her estate or representatives may submit claims for Health Care Expenses incurred by the Eligible Retiree and his or her Dependents prior to the Eligible Dependent's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Dependent's death.

5.6 Nondiscrimination. The Plan Administrator may limit, reallocate or deny any benefit to any Participant who was a highly compensated individual (as defined in Code Section 105(h)) to the extent necessary to avoid discrimination under Code Section 105(h). Any action of the Plan Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

5.7 Transitional Payment. If a transitional payment applies as set forth in the Adoption Agreement, then an additional contribution shall be made as follows. Once the Medicare D Limit established in the Adoption Agreement is met by a Participant for the applicable Plan Year, then the amount set forth in the Adoption Agreement will be credited to the Participant's HRA Account as an additional Benefit Credit for the Plan Year. In order to receive the additional Benefit Credit, a Participant must apply for the additional Benefit Credit by following the requirements established by the Claims Administrator for such purpose from time to time. Once the additional Benefit Credit is made, such additional amount can be used to pay for or reimburse any Health Care Expense, with the exception of any qualifying Part D prescription drug expenses. All other terms and conditions that regularly apply to the Plan and the HRA Account will apply for purposes of the additional Benefit Credit, unless as otherwise set forth in this subsection.

5.8 Catastrophic Coverage Reimbursement. Once a Participant has reached the Catastrophic Coverage Level for the applicable Plan Year set by CMS, all eligible claims for qualifying prescription drug expenses in excess of the Level will be reimbursed by the University for the remainder of the applicable Plan Year with no dollar limit. However, no additional contribution will be made to, and no qualifying prescription drug expenses will be reimbursed from, the Participant's HRA Account. A participant may submit claims for reimbursement by following the requirements established by the Claims Administrator for such purpose from time to time.

ARTICLE VI
CONTINUATION COVERAGE

6.1 Definitions. For purposes of this Article, the following terms shall have the meanings set forth below to the extent they apply to coverage under this Plan:

(a) "COBRA Continuation Coverage" means the continuation of the Plan benefits being provided to a Qualified Beneficiary immediately prior to a Qualifying Event.

(b) "Election Period" means a period of at least sixty (60) days' duration that begins not later than the date on which the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of a Qualifying Event and that ends sixty (60) days after the later of: (1) the date such coverage would otherwise end, or (2) the

date that the Qualified Beneficiary receives notice of his or her right to continued coverage under the Plan pursuant to Section 6.4.

(c) "Qualified Benefits" means the HRA benefit under this Plan.

(d) "Qualified Beneficiary" means the Participant's Spouse, former Spouse, Dependent children, and any Dependent child born to, adopted by, or placed for adoption with a Participant during the period of COBRA Continuation Coverage.

(e) "Qualifying Event" means any of the following events which, but for this Article, would result in the loss of coverage of a Qualified Beneficiary:

(1) the death of a Participant;

(2) the divorce or legal separation of a Participant and his or her Spouse; or

(3) a Dependent child of a Participant ceasing to be classified as a Dependent.

(f) "Similarly Situated Beneficiary" means, in the case of any Qualified Beneficiary who has a Qualifying Event, an individual who has the same coverage options under the Plan that the Qualified Beneficiary would have had if the Qualifying Event had not occurred; provided that determinations of similar status shall be made by the Plan Administrator in accordance with and taking into account the factors permitted under Code Section 4980B and the regulations issued thereunder to the extent such law or regulations apply.

6.2 COBRA Continuation Coverage. The Dependent, Spouse or former Spouse of a Participant may elect COBRA Continuation Coverage under the Plan pursuant to this Article if the Spouse or former Spouse or Dependent is no longer eligible for Qualified Benefits because of a Qualifying Event described in Section 6.1(e).

6.3 Period of Coverage. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be provided coverage identical to that being provided at that time to a Similarly Situated Beneficiary. COBRA Continuation Coverage under this Plan shall continue for up to thirty-six (36) months, but shall be terminated earlier upon the occurrence of any of the following events:

(a) The date the Qualified Beneficiary's HRA Account is exhausted;

(b) The date the Qualified Beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;

(c) Any required monthly premium is not paid when due or during the applicable grace period;

(d) The date, after the date of the Qualified Beneficiary's COBRA election, that he or she becomes covered under another group health plan that does not contain any

exclusion or limitation with respect to any pre-existing condition of the Qualified Beneficiary; or

(e) The Company and its Affiliates cease to provide any group health plan to any employee.

6.4 Notices.

(a) Qualified Beneficiaries must notify the Plan Administrator in writing within sixty (60) days of a Qualifying Event described in Section 6.1(e)(2) or (3).

(b) The Company must notify the Plan Administrator within thirty (30) days of any Qualifying Event described in Section 6.1(e)(1).

(c) Within fourteen (14) days of its receipt of any notice required by subsection (a) or (b) of this Section, the Plan Administrator shall notify the Qualified Beneficiary of his or her right to COBRA Continuation Coverage under the Plan. Any notification to a Spouse or former Spouse of a Participant by the Plan Administrator shall also be treated as notification to all other Qualified Beneficiaries residing with said Spouse at the time such notification is made. Notice from the Plan Administrator shall be deemed complete upon placement of the notice of Election Period in the United States mail, provided there is sufficient postage for first class mailing and said notice is addressed to the Qualified Beneficiary's last known primary residence (any address other than the Qualified Beneficiary's last known primary residence shall only be known to the Plan Administrator if the Qualified Beneficiary specifically notifies the Plan Administrator of the change in address).

6.5 Election of Coverage. Upon notification by the Plan Administrator of his or her right to COBRA Continuation Coverage under the Plan, a Qualified Beneficiary must affirmatively elect COBRA Continuation Coverage before the expiration of the Election Period.

6.6 Contributions. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be required to pay a premium for any period of continued coverage, such premium to be one hundred and two percent (102%) of the cost to the Plan of coverage for Similarly Situated Beneficiaries. The first required payment must be paid within forty-five (45) days of the date the COBRA Continuation Coverage is elected under Section 6.5.

6.7 Alternative Coverage. If made available by the Plan Administrator, a Qualified Beneficiary may elect between COBRA Continuation Coverage and the alternative coverage made available under the Plan. If, prior to the expiration of the Election Period, the Qualified Beneficiary elects COBRA Continuation Coverage in lieu of alternative coverage, his or her right to alternative coverage shall be forever waived and he or she shall not thereafter be entitled to elect the alternative coverage. If, prior to the expiration of the Election Period, the Qualified Beneficiary elects alternative coverage in lieu of COBRA Continuation Coverage, his or her right to COBRA Continuation Coverage shall be forever waived and he or she shall not thereafter be entitled to elect the COBRA Continuation Coverage.

ARTICLE VII
ADMINISTRATION

7.1 Plan Administrator. The Plan Administrator shall be responsible for the performance of all reporting and disclosure obligations under ERISA, and all other obligations required to be performed by the plan administrator under ERISA or the Code, except such obligations and responsibilities as may be delegated under the Plan to such person or entity as the Plan Administrator designates. The Plan Administrator shall be the designated agent for service of legal process with respect to the Plan.

7.2 Duties of the Plan Administrator.

(a) The Plan Administrator shall have the sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, supply omissions, and determine the benefits payable under this Plan. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(1) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(2) To prepare and distribute information explaining the Plan to Participants;

(3) To receive from Participants and Dependents such information as shall be necessary for the proper administration of the Plan;

(4) To keep records of elections, claims, and disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(5) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents as it deems advisable;

(6) To accept, modify or reject Participant elections under the Plan;

(7) To promulgate election forms and claims forms to be used by Participants, which may be electronic in nature;

(8) To determine and enforce any limits on benefit elections hereunder; and

(9) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan, specifically, and without limitation, to recover

erroneous overpayments made by the Plan to a Participant or Dependent, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant or Dependent .

7.3 Allocation and Delegation of Duties.

(a) The Plan Administrator shall have the authority to allocate, from time to time, by instrument in writing filed in its records, all or any part of its responsibilities under the Plan to one or more of its employees, officers or members as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In the exercise of such allocated responsibilities, any action of the employee, officer, or member to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of such employee, officer, or member. The employee, officer, or member to whom responsibilities have been allocated shall periodically report to the Plan Administrator concerning the discharge of the allocated responsibilities.

(b) The Plan Administrator shall have the authority to delegate, from time to time, by written instrument filed in its records, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable (and may authorize such person to delegate such responsibilities to such other person or persons as the Plan Administrator shall authorize) and in the same manner to revoke any such delegation of responsibility. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall periodically report to the Plan Administrator concerning the discharge of the delegated responsibilities.

(c) The Plan Administrator may employ such legal counsel, accountants, consultants, actuaries, and other agents as it shall deem advisable. The compensation of such legal counsel, accountants, consultants, actuaries and other agents and any other expenses incurred by the Plan Administrator in the administration or management of the Plan or in furtherance of its duties hereunder shall be paid by the Plan by reduction of Participant HRA Accounts to the extent not paid by the Company.

7.4 Indemnification. The Companies, jointly and severally, shall indemnify and save the Plan Administrator, and any employees to whom the Plan Administrator has allocated or delegated its responsibilities in accordance with the provisions hereof, harmless from and against all claims, losses, damages, expense, and liability arising from their responsibilities in connection with the administration and management of the Plan which is not otherwise paid or reimbursed by insurance, unless the same shall result from their own willful misconduct.

7.5 Bonding. The Plan Administrator, each person who is a fiduciary under the Plan and each person who handles funds of the Plan, shall be bonded in an amount no less than the amounts required by ERISA Section 412 and the regulations issued thereunder.

7.6 Information to be Supplied by Company. Each Company shall provide the Plan Administrator or its delegate with such information as it shall from time to time need in the discharge of its duties. The Plan Administrator may rely conclusively on the information certified to it by a Company.

7.7 Claims Procedure.

(a) A claimant may submit a claim for benefits under the HRA to the Claims Administrator for payment or reimbursement by March 31 following the end of the Plan Year in which the claim was incurred. Claims for the transitional payment should be submitted to Tufts Support Services. Claims for HRA payments and reimbursements, and claims for prescription drug expenses over the Catastrophic Coverage Level should be submitted to Via Benefits.

(b) Within one hundred and eighty (180) days of receipt by a claimant of a notice under Section 5.3 denying a claim in whole or in part, the claimant or his or her duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator. In connection with such review, the claimant or his or her duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits, and may submit issues and comments in writing. The Plan Administrator shall make a decision promptly, but not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:

(1) specific reasons for the decision;

(2) specific references to the pertinent plan provisions on which the decision is based;

(3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

(4) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and

(5) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

(c) The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If claimant challenges the decision of the Plan Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue the claim in federal court. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

(d) Any claim, suit or action filed in court (or any other tribunal) by or on behalf of a Participant with respect to this Plan must be brought within 12 months of the date the appeal was denied.

7.8 Nondiscriminatory Operation. All rules, decisions, interpretations, and designations by the Plan Administrator under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

ARTICLE VIII
HIPAA

8.1 Purpose. This Article permits the Plan to disclose PHI to the Plan Sponsor to the extent that such PHI is necessary for the Plan Sponsor to carry out its administrative functions related to the Plan. This Article reflects the requirements set forth in 45 C.F.R. § 164.504(f) of HIPAA and the related regulations promulgated by the U.S. Department of Health and Human Services. Any term used in this Article VIII shall have the meaning set forth in HIPAA and guidance issued thereunder.

8.2 HIPAA Privacy Compliance.

(a) *Disclosures to Plan Sponsor*. In accordance with HIPAA, the Plan may disclose summary health information to the Plan Sponsor as requested by the Plan Sponsor to allow it to modify, amend or terminate the Plan, or obtain premium bids from insurers to provide health insurance coverage under the Plan. The Plan may disclose to the Plan Sponsor information on whether an individual is participating or enrolled in the Plan. In addition, the Plan may disclose protected health information to the Plan Sponsor as necessary to allow the Plan Sponsor to perform plan administration functions, as used within the meaning of the HIPAA privacy regulations, including the following functions:

(1) Collection of individual premiums or contributions;

(2) Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, and related functions;

(3) Reviewing health plan performance;

(4) Activities relating to obtaining or renewing health insurance or determining premium pricing for such benefits, or placing a contract for reinsurance of risk relating to such claims;

(5) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development of the Plan, such as conducting cost-management and planning-related analyses, including formulary development and administration, development or improvement of methods of payment or coverage policies;

(7) Business management and general administrative activities of the Plan;

(8) Determination of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;

(9) Billing, claims management, collection activities, and related health care data processing;

(10) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;

(11) Utilization review activities;

(12) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

(A) Name and address;
(B) Date of birth;
(C) Social security number;
(D) Payment history;
(E) Account number;
(F) Name and address of the health care provider and/or health plan; and

(13) Risk adjusting amounts due to enrollee health status and demographic characteristics.

(b) *Access to Medical Information***.** The following employees or individuals under the control of the Plan Sponsor shall have access to the Plan's protected health information to be used solely for the purposes described above:

(1) Members of the Plan Administrator; and

(2) Such other classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

(c) *Plan Sponsor Agreement to Restrictions*. The Plan will not disclose protected health information to the Plan Sponsor until the Plan Sponsor has certified to the Plan that it agrees to:

(1) Not use or disclose protected health information other than as permitted or required by law or as specified above;

(2) Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan;

(3) Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which Company becomes aware;

(4) Make protected health information accessible to the subject individual in accordance with 45 CFR § 164.524;

(5) Allow the subject individuals to amend or correct their protected health information in accordance with 45 CFR § 164.526;

(6) Make available the information to provide an accounting of its disclosures of protected health information in accordance with 45 CFR § 164.528;

(7) Make its internal practices, books and records available to the Secretary of Health and Human Services for determining compliance;

(8) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses as required by 45 CFR § 164.504(f)(2)(ii)(I);

(9) Ensure that any agents, including a subcontractor, of the Plan Sponsor to whom the Plan Sponsor provides protected health information shall also agree to these same restrictions;

(10) Restrict access to protected health information to those classes of employees or individuals identified above; and

(11) Restrict the use of protected health information by those employees identified above for plan administration functions within the meaning at 45 CFR § 164.504(a).

(d) *Noncompliance Resolution.* In the event of noncompliance with the above restrictions by a designated employee or other individual receiving protected health

information on behalf of the Plan Sponsor, the employee or other individual shall be subject to discipline in accordance with the Plan Sponsor's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Official.

8.3 HIPAA Security Compliance.

(a) *Plan Sponsor Obligations*. The Plan Sponsor shall do the following:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that the adequate separation required by 45 CFR § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information;

(4) Report to the Plan any security incident of which it becomes aware;

(5) Make the Plan Sponsor's internal practices, books, and records relating to security of electronic PHI received from the Plan available to the Secretary of Health and Human Services (or any other officer or employee of the U.S. Department of Health and Human Services to whom the authority involved has been delegated) for purposes of determining compliance by the Plan with the HIPAA security standards.

(b) *Exclusions*. The provisions of (a) apply to all disclosures of electronic PHI by the Plan to the Plan Sponsor except:

(1) Disclosures of summary health information to the Plan Sponsor as reasonably requested by the Plan Sponsor to allow it to modify, amend or terminate the Plan, or to obtain premium bids from insurers to provide health insurance coverage under the Plan;

(2) Disclosures of information on whether an individual is participating or enrolled in the Plan; and

(3) Disclosures of information authorized by an individual in accordance with 45 CFR §164.508.

8.4 Other HIPAA Rules.

(a) *Exempt Enrollment Information*. The Plan may disclose to the Plan Sponsor any enrollment information regarding the Plan with respect to any

Participant, Dependent or other individual participating (or formerly participating) in the Plan. Such disclosure is not subject to the requirements of HIPAA.

(b) *GINA.* Notwithstanding the provisions in this Article, the Plan shall not use genetic information for underwriting purposes and shall not disclose genetic information to any person or party (including the Plan Sponsor) for underwriting purposes based upon the rules set forth in Section 164.502(a)(5)(i) of the HIPAA privacy regulations.

(c) *Breach of Unsecured PHI*. If the Plan Sponsor discovers a breach of unsecured PHI, the Plan Sponsor shall notify the Privacy Official of such breach as soon as practicable but in all events within sufficient time for the Plan to carry out its duties and responsibilities pursuant to the requirements of Part 164, Subpart D of the HIPAA privacy regulations.

(d) *Sale of PHI.* The Plan Sponsor shall not directly or indirectly receive remuneration in exchange for any PHI unless the Plan or the Plan Sponsor satisfies the provisions of Section 164.502(a)(5)(ii) of the HIPAA privacy regulations.

(e) *Marketing Restrictions*. For purposes of a disclosure of PHI from the Plan to the Plan Sponsor pursuant to this Article, the term "plan administration function" (as defined in Section 8.2(a)) shall not include any disclosure of PHI the purpose of which would violate the prohibitions on marketing as set forth in Sections 164.501 and 164.508(a)(3) of the HIPAA privacy regulations. In addition, the Plan Sponsor shall not use or disclose any PHI received from the Plan pursuant to this Article that would be in violation of this subsection (e), if such use or disclosure would be performed by or on behalf of the Plan.

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment and Termination. Although the Plan Sponsor intends to maintain the Plan for an indefinite period, the Plan Sponsor reserves the right to amend, modify, or terminate this Plan at any time, in whole or in part, including but not limited to the right to modify persons eligible for participation, benefits paid by the Plan, and the amount of Benefit Credits to be credited, and the right to reduce or eliminate existing HRA Accounts. Notwithstanding anything to the contrary contained in this Section 9.1 or elsewhere in the Plan, the Plan Administrator shall have the authority to approve all technical, administrative, regulatory and compliance amendments to the Plan, and any other amendments that will not increase the cost of the Plan to the Company, as the Plan Administrator shall deem necessary or appropriate.

9.2 Adoption by Affiliates. Any Affiliate, with the consent of the Plan Sponsor and under such terms and conditions as the Plan Sponsor may prescribe, may become a Company hereunder. By its adoption of the Plan and participation therein, each Company agrees to be bound

by the terms of the Plan, as amended from time to time in accordance with Section 9.1. Any Company other than the Plan Sponsor shall have the right at any time and under such terms and conditions as the Plan Sponsor may prescribe (including terms and conditions with respect to the satisfaction of any contingent liability by the Company to the Plan) to withdraw from the Plan on sixty (60) days' written notice to the Plan Sponsor and the Plan Administrator.

9.3 Company Liability. Benefits under the Plan are paid by the Companies out of their general assets. Specifically, and notwithstanding anything herein to the contrary, the Company who employs the Participant as of the date of the Participant's qualifying retirement shall be solely responsible for the payment of benefits to such Participant and his or her family members under this Plan. A Company shall have no liability with respect to the payment of any benefits hereunder to any Participant last employed by any other Company prior to eligibility under the Plan or his or her family members.

9.4 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated and any attempt to do so shall be void and unenforceable.

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

9.6 Facility of Payment. If the Plan Administrator deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator to disburse it, whose receipt shall be complete acquittance therefor. Such payments shall, to the extent thereof, discharge all liability of the Plan Administrator, Plan Sponsor and the Company.

9.7 Status of Benefits. Neither the Company nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator or Company if the Participant has any reason to believe that such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

9.8 Applicable Law. The Plan shall be construed and enforced according to the laws of the state of in which the Plan Sponsor is domiciled, to the extent not preempted by any Federal law.

9.9 Capitalized Terms. Capitalized terms shall have the meaning set forth in Articles I and II.

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

Executed this _____ day of _____, _____.

Plan Sponsor: _____
By: _____
Title: _____

Executed this _____ day of _____, _____.

Affiliate: _____
By: _____
Title: _____