TOWN OF XXX

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

JANUARY 1, 2009

Town of XXX
Health Reimbursement Arrangement (HRA) Plan

As Adopted Effective January 1, 2009

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ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

The Town of XXX, Massachusetts (the "Employer") hereby establishes the Town of XXX Health Reimbursement Arrangement (HRA) Plan (the "Plan") effective January 1, 2009 (the "Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the HRA Account.

1.2 Legal Status

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

ARTICLE II. DEFINITIONS

2.1 Definitions

"Administrator" means The Town of XXX, MA. The contact person is the Treasurer/Collector for The Town of XXX, who has the full authority to act on behalf of the Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Administrator, as described in Section 7.2.

"Benefits" means the reimbursement benefits for Medical Care Expenses described under Article VI.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

"Committee" means the HRA Benefits Committee, if any, as may be appointed by Board of Selectmen of The Town of XXX.

"Compensation" means the wages or salary paid to an Employee by the Employer.

"Dependent" means an individual who is a child enrolled in the Participant's Family coverage in a Rate Saver Health Insurance Plan and who is eligible for tax-free employer-sponsored health coverage under the applicable requirements of Section §152 of the IRC.

Notwithstanding the foregoing, the HRA Account will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Effective Date" of this Plan has the meaning described in Section 1.1.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 3.1.

"Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does <u>not</u> include the following:

(a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer;

(b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer;

(c) any self-employed individual;

(d) any partner in a partnership; and

(e) any more-than-2% shareholder in a Subchapter S corporation, including those deemed to be a more-than-2% shareholder by virtue of the Code § 318 ownership attribution rules. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits in accordance with Section 3.2.

"Employer" means The Town of XXX, Massachusetts.

"Employment Commencement Date" means the first regularly-scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"Enrollment Form" means the form provided by the Administrator or its designee for the purpose of allowing an eligible Employee to participate in this Plan.

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

"Health FSA" means a health flexible spending arrangement as defined in Prop. Treas. Reg. § 1.125-5.

"Highly Compensated Individual" means an individual defined under Code § 105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.

"HRA Account" means the HRA Account described in Section 6.4.

"Medical Care Expenses" has the meaning defined in Section 6.2.

"Open Enrollment Period" with respect to a Plan Year means the month of November in the year preceding the Plan Year, or such other period as may be prescribed by the Administrator.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

"Period of Coverage" means the Plan Year, with the following exceptions:

(a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and

(b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.2. A different Period of Coverage (e.g., monthly) may be established by the Administrator and communicated to Participants.

"Plan" means The Town of XXX HRA Plan as set forth herein and as amended from time to time.

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

"QMCSO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Rate Saver Health Insurance Plan" means the following group health plans that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plans):

- Harvard Pilgrim Health Care Rate Saver
- Network Blue New England Options v.2
- Tufts Health Plan Navigator Rate Saver
- Fallon Community Health Plan Direct Care Rate Saver
- Fallon Community Health Plan Select Rate Saver

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse for tax purposes under the Code).

"Third Party Administrator" means the independent third party the Administrator has hired to provide necessary administrative services to the HRA Plan, including, but not limited to claims processing and payment.

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

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual:

(a) is an Employee;

(b) is eligible for the Town's group insurance program pursuant to the provisions of Massachusetts General Laws C.32B s.2 (d);

(c) is enrolled in a Rate Saver Health Insurance Plan; and

(d) is actively-at-work, provided however, that any Employee on leave under the Family Medical Leave Act (FMLA) due to his or her own serious health condition, or who is otherwise on an approved, paid or unpaid medical leave due to his or her own health condition, shall be considered "actively-at-work" for purposes of this paragraph.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the termination of this Plan;
- the date on which the Employee ceases to be enrolled in a Rate Saver Health Insurance Plan; or
- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis under Section 6.7.

Reimbursements from the HRA Account after termination of participation will be made pursuant to Sections 6.7 and 6.8 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA).

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Employee will be reinstated with the same HRA Account balance that such individual had before termination.

If an Employee (whether or not a Participant) terminates employment and is not rehired within 30 days or ceases to be an Eligible Employee for any other reason for greater than 30 days including (but not limited to) a reduction in hours, and then becomes an Eligible Employee again, the Participant will be eligible for a new, prorated Employer contribution, as described in Section 6.3.

3.4 FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Employee, to the extent required by law or regulation.

3.5 Non-FMLA and Non-USERRA Leaves of Absence

If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described above under Section 3.2.

ARTICLE IV. METHOD AND TIMING OF ENROLLMENT

4.1 Enrollment When First Eligible

An Employee who first becomes eligible to participate in this Plan will commence participation on the first day of the month after the eligibility requirements have been satisfied, provided that an Enrollment Form is submitted to the Administrator or its designee before the first day of the month in which participation will commence. Once enrolled, the Employee's participation will continue from month-to-month and year-to-year until the Employee's participation ceases pursuant to Section 3.2. The Enrollment Form shall identify the Spouse and Dependents whose medical expenses may be submitted to the HRA.

ARTICLE V. BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

When an Eligible Employee becomes a Participant in accordance with Articles III and IV, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Medical Care Expenses, as described in Article VI. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* The Employer funds the full costs of the HRA Accounts.

(b) *Participant Contributions.* There are no Participant contributions for Benefits under the Plan.

(c) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employer contributions to the Plan.

5.3 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

ARTICLE VI. HEALTH REIMBURSEMENT BENEFITS

6.1 Benefits

The Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's HRA Account, as set forth and adjusted under Section 6.3.

6.2 Medical Care Expenses

Under the HRA Account, a Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage.

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible. Also, a Medical Care Expense incurred during one Period of Coverage may not be paid during a later Period of Coverage.

(b) *Medical Care Expenses.* For purposes of this HRA Plan, "Medical Care Expenses" eligible for reimbursement means expenses incurred by a Participant or his or her Spouse or Dependents (but not by a Domestic Partner or Civil Union partner) for out-of-pocket expenses paid solely for a Rate Saver Health Insurance Plan's co-payments, according to the following schedule:

TYPE OF MEDICAL CARE EXPENSE	REIMBURSABLE CO-PAY AMOUNT
All Office Visit Copays and Other Medical Care Expenses Subject to the Primary Care Co-pay	2009: $10.00 per visit 2010: $5.00 per visit 2011: $0.00 per visit
Office visit—Specialist Care	$20 per visit
Emergency Room Visit (not admitted)	$25 per visit
In-patient	$150 per admittance
Same-day Surgery	$75 per incident
Diagnostic Imaging	$50 per incident
Prescription drug—Retail	$10 for each prescription >/= $25
Prescription drug—Mail Order	$20 for each prescription

(c) No other expenses shall be considered Medical Care Expenses, regardless of whether they may be considered expenses for medical care under IRC Code §105 and 213(d). Examples of ineligible expenses are described in subsection (d), below. Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents shall be charged against the Participant's HRA Account.

(d) *Medical Care Expenses Exclusions.* "Medical Care Expenses" shall not include (1) any other medical care expense defined in Code § 105 and 213(d) (including, for example, amounts paid for hospital bills, doctor bills, dental bills, prescription drugs, laboratory tests, etc.) unless such amounts are in the form of co-payments incurred for the specific types of medical care expenses listed in subsection (b) above, and paid under a Rate Saver Health Insurance Plan; (2) health insurance premiums, including but not limited to COBRA premiums, or premiums for individual policies or for any other group health plan (including a plan sponsored by the Employer); and (3) any other expenses not specifically included in subsection (b) above.

(e) *Cannot Be Reimbursed or Reimbursable from Another Source.* Medical Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Rate Saver Health Insurance Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere, the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VI.

6.3 Maximum Benefits

(a) *Annual Maximum Benefits.* The maximum dollar amount that may be credited annually to an HRA Account for an Employee having individual coverage in a Rate Saver Health Insurance Plan is $400.00 per Plan Year. The maximum dollar amount that may be credited annually to an HRA Account for an Employee having family coverage in a Rate Saver Health Insurance Plan is $1,000.00 per Plan Year.

However, the annual maximum benefit amount shall be prorated on a monthly basis and reduced accordingly for Employees who were not enrolled in the Plan on January 1 of the Plan Year, based on the number of full months remaining in the Plan Year, as measured from the first day of the month *following*:

(i) the date of hire (for new employees) or
(ii) the date of benefit eligibility (for newly benefit eligible employees).

(b) *Supplemental HRA Benefits.* The Employer may make Supplemental HRA Benefits available to eligible Participants at the end period for filing Benefit claims of any Plan Year, in an amount determined by the Employer. In that event, Participants who have exhausted their annual maximum benefit during the Plan Year, but who have additional unreimbursed qualified Medical Care Expenses incurred during that year, may submit those expenses to the TPA for consideration for reimbursement. All such claims shall be submitted in accordance with the procedures and timing requirements outlined in Section 6.6(c).

Reimbursement amounts paid as Supplemental HRA Benefits shall be calculated based on an equitable distribution of available funds and shall be made to all eligible Participants who submit qualified claim requests in a timely manner. Supplemental HRA Benefits will be paid in a single lump sum following the close of the grace period for filing Plan Year claims, after all other Benefit requests are considered and adjudicated.

(c) *No Interest*. The HRA Accounts shall not accrue interest.

(d) *Changes*. For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator in his or her sole discretion, and if changed, such change shall be communicated to Employees through the Enrollment Form, a summary document or another document.

(e) *Nondiscrimination.* Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code § 105(h), as may be determined by the Administrator in its sole discretion.

6.4 Establishment of Account

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

(a) *Crediting of Account*s. The annual maximum benefit of $1,000.00 (family coverage) or $400.00 (individual coverage), whichever applies, shall be credited to Eligible Employees' HRA Accounts on the first day of the Plan Year. Otherwise, an Employee's HRA Account will be credited with the applicable maximum benefit as soon as possible *after* the Participant satisfies the eligibility requirements outlined in Section 3.1 and enrolls in the Plan mid-year during the Plan Year.

(b) *Debiting of Account*s. A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

(c) *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

(d) *No Mid-Year Benefit Amount Changes.* The annual maximum benefit shall be a fixed amount set at the beginning of the Plan Year. There will be no changes made to a Participant's annual maximum benefit amount (i.e., either $1,000.00 for family coverage or $400.00 for individual coverage) on account of a change in family status (e.g., marriage, divorce, birth or adoption, etc.) or other life event that occurs mid-year during the Plan Year.

6.5 No Carryover of Account Balances

Any balance that remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for that Period shall be forfeited. **Unused HRA amounts shall *not* carry over to a subsequent Period of Coverage** (but see the discussion of COBRA in Section 6.8). Also, other than as provided for in Section 3.3, upon termination of employment or other loss of eligibility, the Participant's coverage ceases, and

expenses incurred after such time will not be reimbursed unless COBRA is elected as provided in Section 6.8.

6.6 Reimbursement Procedure

(a) *Timing.* Within 30 days after receipt by the Third Party Administrator of a reimbursement claim from a Participant, the Third Party Administrator (TPA) will reimburse the Participant for the Participant's Medical Care Expenses (if the TPA approves the claim), or the TPA will notify the Participant that his or her claim has been denied (See Section 7.1 for procedures for appeals procedures). This time period may be extended for an additional 15 days for matters beyond the control of the TPA, including in cases where a reimbursement claim is incomplete. The TPA will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) *Method*. All HRA reimbursements will be made by direct deposit via electronic funds transfers to the Participant's personal bank account. Participants must provide the Plan with direct deposit information to facilitate Plan reimbursements.

(c) *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the TPA in such form as the Administrator or its designee, the TPA, may prescribe, by no later than January31 following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

- the person or persons on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source. The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator or the TPA may request. .

(d) *Claims Denied*. For reimbursement claims that are denied, see the Appeals Procedures in Article VII.

6.7 Reimbursements After Close of Period of Coverage

A Participant will not be able to receive reimbursements for Medical Care Expenses incurred after a Period of Coverage ends from amounts remaining at the close of the immediately prior Period of Coverage.

However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the immediately prior Period of Coverage from amounts remaining at the close of that Period, provided the Participant (or the Participant's

estate) files a claim by the January31 following the close of the Plan Year in which the Medical Care Expense arose (*i.e.*, the claims "run-out" period). Otherwise, any unused amounts remaining at the close of the claims run out period shall revert to the Employer.

6.8 Reimbursements After Termination; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates (unless COBRA is elected, as discussed below).

Such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim by January31 following the close of the Plan Year in which the Medical Care Expense arose.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the HRA Account because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the HRA Account the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly-situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants.

Upon satisfactorily meeting the eligibility requirements set forth in Section 3.1(c) (*i.e.*, enrollment in a Rate Saver Health Insurance Plan under COBRA) *and* enrollment in this Plan for COBRA, Qualified Beneficiaries shall be credited with the maximum annual reimbursement amount that is made available to similarly-situated non-COBRA beneficiaries. A premium for continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by COBRA.

6.9 Compliance With COBRA, HIPAA and Other Laws

Benefits under this Plan shall be provided in compliance with COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

6.10 Coordination of Benefits; HRA to Reimburse First

In general, benefits under this Plan are intended to pay benefits solely for the specified Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan.

However, if the Participant's Medical Care Expenses are covered by both this Plan and by a Health FSA, then in general, this Plan shall pay first. Health FSA funds shall not be used for reimbursement of such Medical Care Expenses until it becomes known, on an individual expense basis, that no further reimbursement for a particular co-payment expense(s) is available under this Plan. In that event, Health FSA funds may be used to reimburse the remaining balance of that expense(s).

ARTICLE VII. APPEALS PROCEDURES

7.1 Procedure if Benefits Denied Under This Plan

If a claim for benefits under this Plan is wholly or partially denied, the Plan shall notify the Participant in writing within thirty (30) days of receipt of a properly-filed, complete claim. This written notice will include the reason for the denial, notify the Participant regarding the procedures for appealing the adverse decision, and where applicable, provide a brief description of any additional material or information that would be necessary to perfect the claim.

The Plan shall provide all Participants with the opportunity for denied claims to be reconsidered upon appeal. The Committee shall act on behalf of the Administrator with respect to all claim appeals. Any claim appeals must be made in writing, within 180 days of the date of the denial, and shall be sent to the Committee (or if none, to the Administrator) at the address below:

Human Resources Department
Town Hall
525 Washington Street
XXX, MA 02482

The Committee (or Administrator) shall notify the Participant regarding the outcome of his or her claim appeal, in writing, within sixty (60) days after receiving a properly-filed, complete claim appeal. This written notice shall include the reason that the appeal was denied.

The Committee's (or Administrator's) decision regarding the outcome of all claim appeals shall be final. The Plan grants the Committee (or Administrator) full discretionary authority to make all final determinations of any denied claims submitted for appeal by any Participant.

ARTICLE VIII. RECORDKEEPING AND ADMINISTRATION

8.1 Administrator

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

8.2 Powers of the Administrator

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

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 8.2, the Committee shall exercise such exclusive power with respect to any appeal of a claim under Section 7.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

(f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;

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

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

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

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

8.3 Reliance on Participant, Tables, etc.

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

8.4 Provision for Third-Party Plan Service Providers

The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

8.5 Fiduciary Liability

To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

8.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

8.7 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall

not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

8.8 Inability to Locate Payee

If the Administrator or its designee is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

8.9 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE IX. HIPAA PROVISIONS

9.1 Use of Protected Health Information

The Plan will use and disclose protected health information (PHI), as defined in 45 C.F.R. Parts 160 and 164, to the extent of and in accordance with the uses and disclosures permitted by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to payment for health care and health care operations as defined in the Plan's HIPAA Privacy Notice.

The "Plan Sponsor" is the Town of XXX. The Plan will disclose PHI to the Plan Sponsor only in accordance with the provisions below.

9.2 Plan Sponsor Obligations With Respect to PHI

With respect to PHI, the Plan Sponsor agrees to:

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

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

(c) Not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor or employer unless authorized by an individual;

(e) Report to the Plan any PHI use or disclosure of information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to an individual in accordance with HIPAA's access requirements;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

(j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for

the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

9.3 Plan Sponsor's Access to PHI

In accordance with HIPAA, only the following employees or classes of employees listed below may be given access to PHI:

- All employees of the Human Resources Department

These persons may use and disclose PHI only for Plan administration functions that the Plan Sponsor performs. If the persons described herein or any other employees do not comply with the Plan's guidelines, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan Sponsor shall cooperate with the Plan to correct and mitigate any such noncompliance.

9.4 Security of Electronic PHI

With regards to the security of electronic PHI (ePHI), the Plan Sponsor will:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI that it creates, receives, maintains, or transmits on behalf of the group health plan;

(b) Ensure that the adequate separation discussed above, specific to ePHI, is supported by reasonable and appropriate security measures;

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

(d) Report to the Plan any security incident of which it becomes aware concerning ePHI.

ARTICLE X. GENERAL PROVISIONS

10.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

10.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

10.3 Amendment and Termination

The Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Selectmen or by any person or persons authorized by the Employer's Board of Selectmen (*i.e*., the Board of Selectmen's designee) to take such action.

10.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the Commonwealth of Massachusetts, to the extent not superseded by the Code or any other federal law.

10.5 Code Compliance

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

10.6 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer 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 Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.7 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.8 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

10.9 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

10.10 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

* * *

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising The Town of XXX HRA Plan, The Town of XXX, Massachusetts has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 2008.

The Town of XXX, Massachusetts

By: _____

Its: _____

Witness
Signature:_____