

HEALTH REIMBURSEMENT ARRANGEMENT

PLAN DOCUMENT

AMENDED AND RESTATED JANUARY 1, 2008

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ADOPTION INFORMATION

PLAN TYPE: Health Reimbursement Arrangement (HRA)

PLAN NAME: City of New London Health Reimbursement Arrangement

EMPLOYER, PLAN SPONSOR AND PLAN ADMINISTRATOR:

Employer: City of New London 215 N. Shawano St. New London, WI 54961

Plan Administrator & Sponsor: WPPI Benefit Plan Trust 1425 Corporate Center Drive
Sun Prairie, WI 53590

Claims Administered by: Midwest Security Administrators Inc., dba UMR 3100 AMS Blvd
P.O. Box 12003 Green Bay, WI 54307 2003

EMPLOYEE CLASSIFICATION: All employees enrolled in the Employer-sponsored medical plan, who for whatever reason cannot participate in the Health Savings Account arrangement.

EMPLOYEE NEW HIRE ELIGIBILITY: First of the month following hire.

PLAN NUMBER: 0WPP040

ORIGINAL EFFECTIVE DATE: for the HRA arrangement 1/1/08 for the plan 1/1/1998

PLAN YEAR: calendar year

PLAN PARAMETERS: The Health Reimbursement Arrangement is available for payment of eligible health plan deductible expenses according to the following schedule:

SINGLE COVERAGE: The deductible is \$1500.00. The employee is responsible for 25% of eligible deductible expenses in 2008, 40% of eligible expenses in 2009 and 50% there after. The Health Reimbursement Arrangement will reimburse the employee for the balance of these expenses in each year.

FAMILY COVERAGE: The deductible is \$3000. The employee is responsible for 25% of eligible deductible expenses per family in 2008, 40% in 2009 and 50% thereafter. The Health Reimbursement Arrangement will reimburse the employee for the balance of these expenses in each year.

MAXIMUM HRA CONTRIBUTION PER PLAN YEAR: Employer contribution is as described under single coverage, family coverage above.

ADOPTION INFORMATION (CONTINUED)

Important: An Explanation of Benefits (EOB) from your insurance carrier must be submitted for every expense applied to your health plan deductible and for which you request reimbursement from the HRA plan. Claims submitted without the required documentation cannot be considered for payment.

PLAN YEAR CARRYOVER PROVISION: Any unused Health Reimbursement Arrangement dollars at calendar year end remain in the employee's designated HRA account for use in subsequent years.

EMPLOYER ALLOCATIONS TO THE PLAN: The entire employer contribution to the HRA will be made in January of each year according to the schedule set forth above.

CLAIMS PROCESSING SCHEDULE: Employees are responsible for managing their HRA account. They are given the right to disburse funds. Funds are only to be disbursed to medical providers upon receipt of an EOB from UMR. The City is owner and custodian of the account and will monitor withdrawals. Employees will be asked to present EOB's to justify questionable withdrawals. Should the employee abuse this privilege the handling of the account will be turned over to a third party administrator who will require submission of EOB's prior to payment. Specific terms of payment handling and submission will be determined if such a system is required.

EMPLOYEE TERMINATION GUIDELINES:

NUMBER OF DAYS TO INCUR CLAIMS AFTER LAST DAY OF EMPLOYMENT: The end of the month in which termination occurs.

NUMBER OF DAYS TO SUBMIT CLAIMS AFTER LAST DAY OF EMPLOYMENT: The terminated employee has the remainder of the Plan Year in which termination occurs, plus until March 31st after that Plan Year ends, to submit claims for expenses that were incurred prior to the end of the month in which termination occurred.

HEALTH REIMBURSEMENT ARRANGEMENT

As used in this Plan, the following words and phrases shall have the meanings set forth herein unless a different meaning is clearly required by the context:

ARTICLE I DEFINITIONS

- 1.1** “Code” means the Internal Revenue Code of 1986, as amended.
- 1.2** “Dependent” means any individual who qualifies as a dependent under an Insurance Contract or under Code Section 152 (as modified by Code Section 105(b)) or as amended by any regulation or ruling of the Internal Revenue Service. Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall also be considered a Dependent under this Plan.
- 1.3** “Effective Date” means the date specified in the Adoption Information.
- 1.4** “Eligible Employee” means any employee who qualifies for Health Insurance benefits under the City’s policies. Generally this any employee who averages or is expected to average 30 hours of work per week over a calendar year period.
- 1.5** “Employee” means any person who is employed by the Employer and receives a W2 statement of wages earned and taxes withheld.
- 1.6** “Employer” means the City of New London.
- 1.7** “Employer Contribution” means the amounts contributed to the Plan by the Employer.

- 1.8** "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.
- 1.9** "Participant" means any Eligible Employee who has satisfied the requirements of Section 2.1 and has not for any reason become ineligible to participate in the Plan.
- 1.10** "Plan" means this Plan Document and the Adoption Information as adopted by the Employer, including all amendments thereto.
- 1.11** "Plan Administrator" means the individual(s) or committee appointed by the Employer to carry out the administration of the Plan. In the event the Plan Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Plan Administrator.
- 1.12** "Plan Year" means the time period as set forth in the Adoption Information.
- 1.13** "Premiums" mean the Participant's cost for any health plan coverage.
- 1.16** "Qualifying Medical Expenses" means any expense eligible for reimbursement under the Health Reimbursement Arrangement which would qualify as a "medical expense" or "medical care" (as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder) of the Participant, the Participant's spouse or a Dependent and not otherwise used by the Participant as a deduction in determining the Participant's tax liability under the Code or reimbursed under any other health coverage, including a Medical Flexible Spending Account. Qualifying Medical Expenses covered by this Plan are limited as stated in the Adoption Information. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

ARTICLE II PARTICIPATION

2.1 Eligibility

Any Eligible Employee shall be eligible to participate hereunder on the date such Employee satisfies the conditions of new hire eligibility as defined in the Adoption Information.

2.2 Effective Date of Participation

An Eligible Employee shall become a Participant effective as of the date on which he satisfies the requirements of Section 2.1.

If an Employee, who has satisfied the Plan's eligibility requirements and would otherwise have become a Participant, shall go from a classification of a noneligible Employee to an Eligible Employee, such Employee shall become a Participant on the date such Employee becomes an Eligible Employee or, if later, the date that the Employee would have otherwise entered the Plan had the Employee always been an Eligible Employee.

If an Employee, who has satisfied the Plan's eligibility requirements and would otherwise become a Participant, shall go from a classification of an Eligible Employee to a noneligible class of Employees, such Employee shall become a Participant in the Plan on the date such

Employee again becomes an Eligible Employee, or, if later, the date that the Employee would have otherwise entered the Plan had the Employee always been an Eligible Employee.

2.3 Termination of Participation

This Section shall be applied and administered consistent with any rights a Participant and the Participant's Dependents may be entitled to pursuant to Code Section 4980B, Section 7.13 of the Plan, or as stated in the Adoption Information. In the case of the death of the Participant, any remaining balances may only be paid out as reimbursements for Qualifying Medical Expenses and shall not constitute a death benefit to the Participant's estate and/or the Participant's beneficiaries.

ARTICLE III BENEFITS

3.1 Establishment of Plan

- (a) This Health Reimbursement Arrangement is intended to qualify as a Health Reimbursement Arrangement under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder.
- (b) Participants in this Health Reimbursement Arrangement may submit claims for the reimbursement of Qualifying Medical Expenses as defined under the Plan and the Adoption Information.
- (c) The Employer shall make available to each Participant an Employer Contribution as stated in the Adoption Information, for the reimbursement of Qualifying Medical Expenses.
- (d) This Plan shall not be coordinated or otherwise connected to the Employer's cafeteria plan (as defined in Code Section 125), except as permitted by the Code and the Treasury regulations thereunder, to the extent necessary to maintain this Plan as a Health Reimbursement Arrangement.

3.2 Nondiscrimination Requirements

- (a) It is the intent of this Health Reimbursement Arrangement not to discriminate in violation of the Code and the Treasury regulations thereunder.
- (b) If the Plan Administrator deems it necessary to avoid discrimination under this Health Reimbursement Arrangement, it may require reduced benefits provided to "highly compensated individuals" (as defined in Code Section 105(h)) in order to assure compliance with this Section. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

3.3 Health Reimbursement Arrangement Claims

- (a) The Plan Administrator shall direct the reimbursement to each eligible Participant for all Qualifying Medical Expenses. All Qualifying Medical Expenses eligible for reimbursement pursuant to Section 3.1(b) shall be reimbursed during the Plan Year, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Qualifying Medical Expenses were incurred while the Employee was eligible and a Participant in the Health Reimbursement Arrangement Plan. Claims must include receipts or documentation that the expense being incurred is eligible for reimbursement. Expenses may be reimbursed in subsequent Plan Years. However, a Participant may not submit claims incurred prior to beginning participation in the Plan and/or the Effective Date of the Plan, whichever is earlier.
- (b) Notwithstanding the foregoing, unless otherwise stated in the Adoption Information, Qualifying Medical Expenses must be claimed and reimbursed under the Employee's Medical Flexible Spending Account, if existent, before reimbursement is eligible under this Health Reimbursement Arrangement Plan.
- (c) Claims for the reimbursement of Qualifying Medical Expenses shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within the period stated in the Adoption Information immediately following the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement.
- (d) Reimbursement payments under this Plan shall be made directly to the Medical provider.
- (e) If the maximum amount available for reimbursement for a Plan Year is not utilized in its entirety, such remainder shall be carried forward to another Plan Year, unless otherwise stated in the Adoption Information.

3.4 Debit and Credit Cards

- (a) If the Debit Card or other debit instrument is offered, Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of allowable expenses, subject to the following terms:
 - (1) Each Participant issued a card shall certify that such card shall only be used for allowable expenses. The Participant shall also certify that any allowable expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.
 - (2) Such card or instrument shall be issued in a manner determined by the Plan Administrator and reissued on a periodic basis providing the Participant remains a Participant in the Health Reimbursement Arrangement. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant withdraws from the Health Reimbursement Arrangement.

- (3) The dollar amount of coverage available on the card shall be the amount contributed by the Employer for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth on the Adoption Information.
- (4) The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.
- (5) The cards shall only be used for Medical Expense purchases at accepted providers.
- (6) Such purchases by the cards shall be subject to substantiation by the Administrator or Plan Service Provider, usually by submission of a receipt from a merchant or service provider describing the service or product, the date of the purchase and the amount. Some charges shall be considered substantiated at the time of charge by the nature of the charge, such as co-payments. Some charges shall be considered substantiated due to their "recurring" nature, in which the expenses match expenses previously approved as to amount, provider, and time period. At point of sale, the service provider or merchant can provide information to the Administrator or Plan Service Provider to substantiate the charge. All charges shall be conditional pending confirmation and substantiation.
- (7) If such purchase is later determined by the Administrator or Plan Service Provider not to be a Qualifying Medical Expense, the Administrator or Plan Service Provider, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator or Plan Service Provider shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.
 - (i) Repayment of the improper amount by the Participant;
 - (ii) Claims substitution or offset of future claims until the amount is repaid;
 - (iii) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law.

ARTICLE IV ERISA PROVISIONS

4.1 Claims for Benefits

Any claim for Benefits shall be made to the Plan Administrator or Plan Service Provider. The following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	
Response by Participant	45 days
Review of claim denial	60 days

The Plan will provide written or electronic notification of any claim denial. The notice will state:

- (1) The specific reason or reasons for the denial.
- (2) Reference to the specific Plan provisions on which the denial was 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 description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under section 502 of ERISA following a denial on review.
- (5) 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.
- (6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (1) was relied upon in making the claim determination;
- (2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

4.2 Named Fiduciary

The “named Fiduciaries” of this Plan are (1) the Employer and (2) the Plan Administrator. The named Fiduciaries shall have only those specific powers, duties, responsibilities, and obligations as are specifically given them under the Plan including, but not limited to, any agreement allocating or delegating their responsibilities, the terms of which are incorporated herein by reference. In general, the Employer shall have the sole responsibility for providing benefits under the Plan; and shall have the sole authority to appoint and remove the Plan Administrator; and to amend the elective provisions of the Adoption Information or terminate, in whole or in part, the Plan. The Plan Administrator shall have the sole responsibility for the administration of the Plan, which responsibility is specifically described in the Plan. Furthermore, each named Fiduciary may rely upon any such direction, information or action of another named Fiduciary as being proper under the Plan, and is not required under the Plan to inquire into the propriety of any such direction, information or action. It is intended under the Plan that each named Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the Plan. Any person or group may serve in more than one Fiduciary capacity.

4.3 General Fiduciary Responsibilities

The Plan Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

- (a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;
- (b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

- (c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

4.4 Nonassignability of Rights

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

ARTICLE V ADMINISTRATION

5.1 Plan Administration

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

- (a) To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- (b) To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- (d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
- (e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan;
- (f) To approve reimbursement requests and to authorize the payment of benefits;
- (g) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and
- (h) To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of the Health Reimbursement Arrangement regulations defined by the Internal Revenue Service and the Department of Treasury.

5.2 Examination of Records

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

5.3 Indemnification of Plan Administrator

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

ARTICLE VI AMENDMENT OR TERMINATION OF PLAN

6.1 Amendment

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

6.2 Termination

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further reimbursements shall be made.

No further additions shall be made, but all payments shall continue to be made for a reasonable amount of time as specified by the Administrator. Any amounts remaining in any account as of the end of the Plan Year in which Plan termination occurs shall be forfeited after the expiration of the filing period.

ARTICLE VII MISCELLANEOUS

7.1 Plan Interpretation

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 7.11.

7.2 Gender and Number

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

7.3 Written Document

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 105 and any Treasury regulations thereunder.

7.4 Exclusive Benefit

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

7.5 Participant's Rights

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

7.6 Action by the Employer

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

7.7 No Guarantee of Tax Consequences

Neither the Plan Administrator, the Employer, nor the Plan Service Provider makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal, state or local (if applicable) income tax purposes, Social Security or Medicare taxes, or that any other federal, state or local (if applicable) income tax, Social Security or Medicare tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal, state or local (if applicable) income tax, Social Security or Medicare tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

7.8 Indemnification of Employer by Participants

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

7.9 Funding

Unless otherwise required by law, amounts made available by the Employer need not be placed in trust, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

7.10 Governing Law

This Plan shall be construed and enforced according to the Code, ERISA, and the laws of the state or commonwealth in which the Employer's principal office is located (unless otherwise designated in the Adoption Information), other than its laws respecting choice of law, to the extent not pre-empted by ERISA.

7.11 Severability

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

7.12 Headings

The headings and subheadings of this Plan have been inserted for convenience of reference and are to be ignored in any construction of the provisions hereof.

7.13 Continuation of Coverage

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each qualified beneficiary (as defined in Code Section 4980B) will be entitled to continuation coverage as prescribed in Code Section 4980B.

7.14 Family and Medical Leave Act

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with the regulations.

7.15 Health Insurance Portability and Accountability Act

Notwithstanding anything in the Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

7.16 Uniformed Services Employment and Reemployment Rights Act

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

7.17 Compliance with HIPAA Privacy Standards

- (a) If this Plan is subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.
- (b) The Plan shall not disclose Protected Health Information to any member of Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (c) Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (d) The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

- (1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
- (2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:
 - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigation of any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

The Employer must provide certification to the Plan that it agrees to:

- (1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- (2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
- (5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

- (8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

7.18 Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. Seq., the "Security Standards"):

- (a) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (b) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (c) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 7.17.

IN WITNESS WHEREOF, this Plan document is hereby executed this _____ day

of _____, _____.

Employer

By _____

ADOPTION RESOLUTION

The undersigned of **City of New London** (the Employer) hereby certifies that the following resolutions were duly adopted and that such resolutions have not been modified or rescinded:

RESOLVED, that the form of amended Health Reimbursement Arrangement effective January 1, 2008, is hereby approved and adopted and that the proper officer(s) of the Corporation are hereby authorized and directed to execute the Plan.

RESOLVED, that the Plan Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

The undersigned further certifies that the **City of New London** Health Reimbursement Arrangement as amended and restated is hereby approved and adopted.

Signature

Title: _____

Signature

Title: _____

Signature

Title: _____