City of Forney
SECTION 105
HEALTH REIMBURSEMENT PLAN

PLAN DOCUMENT &
SUMMARY PLAN DESCRIPTION

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I. Introduction

City of Forney, (the "Entity"), hereby establishes this Section 105 Health Reimbursement Plan ("Plan"), as an addition to its Medical Insurance Plan, in order to permit reimbursement of certain Medical Care Expenses. The Plan is intended to be a self-funded medical expense reimbursement plan under Code Section 105, so that all benefits payable hereunder are excluded from gross income. Employees do not contribute to the Plan, and this Plan does not interact with a Section 125 cafeteria plan in such a way to permit employees to use salary reduction to indirectly fund the Plan. In no event will benefits be provided in the form of cash or any other taxable or nontaxable benefit, except for reimbursement as provided in this Plan. The Plan shall not be deemed to constitute a contract between the Entity and any employee. Subject to the above, the Plan is governed by the terms, provisions and conditions described herein.

This Plan is intended to qualify as a health reimbursement arrangement as described in IRS Notice 2002-45 and Revenue Ruling 2002-41, and to comply with IRS Notice 2013-54 and shall be interpreted to accomplish those objectives. This Plan is being offered as an integrated Plan to Eligible Employees exclusively in conjunction with a group health plan providing minimum value pursuant to Section 36B(c)(2)(C)(ii) of the Internal Revenue Code.

The Plan is effective as of 12:01 a.m. on January 1, 2018.

II. Schedule of Benefits

Benefits available under the Plan are listed in Appendix A – HRA Diagram.

Insured incurs an expense that is applied to their plan year in-network deductible.Plan: $6000 (2x)

Employee submits EOB attached to copy of HRA Reimbursement Form to Flores.

Insured is responsible for initial $3000 of deductible. HRA will cover remaining $3000 (up to 2x)

The Entity prior to the beginning of a new plan year may adjust the amount covered by this plan at its discretion.

Excluded Expenses

Any and all expenses excluded by the Group Health Plan.

This Plan operates in conjunction with the Group Health Plan and pays Covered Expenses after satisfaction of the Covered Person prior to reimbursement, as shown in Appendix A.

III. Eligibility and Participation

Eligible Employee: Insured incurs an expense that is applied to their plan year in-network deductible.Plan: $6000 (2x)

Eligible Dependents: Any dependent of the Eligible Employee, provided that said dependent is covered by the Group Health Plan as a dependent of the Eligible Employee.

An Eligible Employee, as well as his or her Eligible Dependents, will automatically become covered by this Plan upon becoming covered by the Group Health Plan.

Continuation During Leave of Absence

If the Entity is covered by the Family and Medical Leave Act ("FMLA") and if a Participant goes on an FMLA leave, coverage under this Plan shall continue if coverage continues under the Group Health Plan, as allowed by the FMLA. If the leave of absence is not covered by the FMLA for any reason, then coverage under this Plan shall continue if coverage under the Group Health Plan continues. Further, coverage under this Plan shall continue if required by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA").

IV. Reimbursement and Maximum Reimbursement Amount

This Plan will reimburse the Participant for Medical Care Expenses incurred by the Covered Person while covered by the Plan, subject to the following conditions per Benefit Year. An expense is incurred when the service is provided, and not when the bill is sent or payment is made to the provider.

1. The reimbursement amount shall be limited per Benefit Year to the Maximum Reimbursement Amount shown in Appendix A.

2. Before reimbursement by this Plan, the Covered Person Payment Prior to Reimbursement, as shown in Appendix A, must first be paid. This means that this Plan's reimbursement will be available only after the threshold as listed in Appendix A has been satisfied.

3. Any reimbursement under this Plan must be substantiated as requested by the Claims Administrator on a form or forms approved by the Claims Administrator.

4. No payment will be made hereunder to the extent that the expense has been reimbursed or is reimbursable to or on behalf of the Covered Person from any other source. Evidence that this requirement is satisfied must be substantiated as requested by the Claims Administrator.

The Maximum Reimbursement Amount shall be determined as of the beginning of the Benefit Year or, if later, the date Plan participation begins. In the event the Participant changes coverage options under the Group Health Plan during the Benefit Year (*e.g.,* changes from employee only coverage to employee and family coverage) and, as a result, his or her deductible under the Group Health Plan, the Maximum Reimbursement Amount under this Plan shall be adjusted accordingly, based on the date of the Change in Status. If participation in the Plan ends and begins again during the same Benefit Year, such as in the case of termination of employment followed by rehire, the prior Maximum Benefit Amount will be reinstated upon re-participation (reduced by any reimbursements from the Plan prior thereto) as though participation had not ended. A Participant is not entitled to receive payment for any unused portion of his or her Maximum Reimbursement Amount per Benefit Year.

V. Claims

a. You can submit a claim for reimbursement at any time during the Benefit Year. Obtain a claim form from the Claims Administrator or the Human Resources department. Attach an Explanation of Benefits from the Group Health Plan showing that the amount was not paid because it was applied to the deductible under the Group Health Plan. The Claims Administrator may request additional documentation in order to substantiate the claim. Approved reimbursements will be made Weekly. However, the Plan may require a minimum amount of submitted claims before a reimbursement will be made.

b. Submit your Explanation of Benefits (EOB), and the completed HRA Reimbursement Claim form to the Claims Administrator at:

c. Claims must be filed by February 28 after the end of the Benefit Year in which expenses were incurred. If not filed in a timely manner the Plan will not reimburse the expense.

d. Within 30 days after receipt by the Claims Administrator of a claim for reimbursement, the Plan will make reimbursement for Medical Care Expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied.

The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the 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 description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request.

Appeal Process

In the event a claim for benefits is denied, the claimant or his or her duly authorized representative, may appeal the denial to the Plan Administrator (the "Entity") within 180 days after receipt of written notice of the denial. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal should be filed within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or you will lose the right to appeal the denial and the right to file a civil action in court as described at Section XI, Rights of Employees Under ERISA. In pursuing an appeal, the claimant or the duly authorized representative:

a. must request in writing that the Plan Administrator review the denial;

b. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and

c. may submit written issues and comments, documents, records, and other information regarding the claim.

Your appeal will be reviewed by the Plan Administrator, and your written comments, documents, records, and other information you submitted will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of your appeal. If the decision on review is adverse to you, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (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. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, you will be provided either the specific rule, guideline, protocol, or other similar criterion, or you will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review, and you have the right to pursue your rights under ERISA, including your right to file a lawsuit, as described in Section XI, Rights of Employees Under ERISA.

The claim and appeal procedures explained above will be interpreted consistent with regulations issued by the U.S. Department of Labor.

VI. Termination of Participation

The coverage of any Covered Person shall terminate the earlier of the following dates:

a. The date the Plan terminates;

b. The date the Group Health Plan terminates; or

c. The date the Covered Person ceases to be covered by the Group Health Plan, unless coverage is continued under this Plan pursuant to a COBRA election.

When participation terminates, reimbursement will not be made for expenses incurred after termination of participation. A Participant may request reimbursement for expenses incurred prior to termination of participation, provided that a claim is filed within 60 days following the close of the Benefit Year in which participation ceased.

If the Entity is covered by COBRA, a Covered Person whose coverage terminates under the Plan 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 Plan the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA).

Notwithstanding the foregoing, effective at the beginning of the 2014 Plan Year, and during every subsequent Plan Year, a Participant shall be permitted to opt out of the HRA and waive future reimbursements from the HRA once each year.

VII. Continuation of Coverage (COBRA) – This Section applies only if the Entity is subject to COBRA

Introduction

Important information about rights you may have to COBRA continuation coverage are described below, including when COBRA coverage may be available to you and what you need to do to protect the right to receive it. As a general rule, COBRA applies to employers that normally employed 20 or more employees during the preceding calendar year.

COBRA coverage is a temporary continuation of group health coverage that is available to covered employees, spouses, and dependent children under certain circumstances when their group health coverage would otherwise end. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act.

This Plan will offer COBRA coverage if the Entity is subject to COBRA, and the coverage that is offered will be the coverage required by law. Nothing in this explanation is intended to change the requirements of law.

What is COBRA coverage?

COBRA coverage is a continuation of group health plan coverage when that coverage would otherwise end because of certain events called "qualifying events." Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly given, COBRA coverage must be offered to each person losing group health plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the group health plan is lost because of the qualifying event. Certain newborns and newly adopted children may also be qualified beneficiaries. This is discussed in more detail below under the heading called "Other Individuals Who May be Qualified Beneficiaries." The word "you" below generally refers to each person covered by the group health plan who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the group health plan provides to other participants and beneficiaries who are not receiving COBRA coverage. If the coverage for others changes, it will change in the same way for those who have elected COBRA. Each qualified beneficiary who elects COBRA coverage will have the same rights and responsibilities, and will be subject to the same terms and conditions for coverage, as others who are covered by the group health plan but who have not elected COBRA (including any annual enrollment and special enrollment rights), except that those who elect COBRA must pay for the entire cost of COBRA coverage, plus an administrative fee.

Qualifying Events

If you are an employee, you will be entitled to elect COBRA if you lose group health coverage under the terms of the Plan because of one of the following qualifying events:

(1) Your hours of employment are reduced; or
(2) Your employment ends for any reason (other than your gross misconduct).

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose group health coverage under the terms of the Plan because of any of the following qualifying events:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason (other than for gross misconduct); or
(4) You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation; or
(5) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose group health coverage under the Plan because of any of the following qualifying events:

(1) Your parent-employee dies;
(2) Your parent-employee's hours of employment are reduced;
(3) Your parent-employee's employment ends for any reason (other than for gross misconduct);
(4) Your parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
(5) Your parents become divorced or legally separated; or
(6) You no longer meet the group health plan's definition of a dependent child and are therefore no longer eligible.

When is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been properly notified that a qualifying event has occurred. When the qualifying event is the end of employment (other than for gross misconduct), the reduction of hours of employment, the death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. You need not provide notice of these particular events. However, you must give notice of other qualifying events, as explained below.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the group health plan as a result of the qualifying event. Notice can be given by the employee, by a qualified beneficiary, or by their representative.

To provide this notice, you must send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within the 60-day period described in the preceding paragraph. You must use an appropriate envelope with correct postage and the correct address. Any additional procedures required by the Plan Administrator are attached.

If your notice is not properly and timely provided within the 60-day period described above, you will lose your right to elect COBRA.

After your notice has been received, you may be asked to provide additional information. For example, you may need to provide a copy of a divorce decree, a birth certificate, or a school transcript.

Electing COBRA Coverage

Once the Plan Administrator receives notice and satisfactory proof that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary who loses group health coverage because of the qualifying event. You will receive information about electing COBRA, and you should follow the instructions given.

Independent Election Rights

Each qualified beneficiary will have a separate and independent right to elect COBRA coverage under the group health plan that covered him or her on the day before the qualifying event. For example, if both the employee and spouse have the right to elect COBRA coverage, the employee can elect COBRA even if the spouse does not. If several dependent children have the right to elect COBRA, COBRA can be elected for only one, for some, or for all of the dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries. Also, a parent or legal guardian may elect COBRA on behalf of their minor dependent children.

60-Day Election Period

To elect COBRA, you must complete the election form that will be provided to you and timely return it as instructed. Under federal law, you have 60 days to elect COBRA. The 60-day period is measured from the later of the date coverage is lost under the terms of the Plan or the date of the COBRA election notice. If you want to elect COBRA, the election form must be properly completed, placed in an appropriate envelope with correct postage and correct address, and postmarked within the 60-day election period. If mailed, your election is considered to have been made on the date that it is postmarked. The form should be mailed to the Plan Administrator whose address is shown at the end of this explanation about COBRA. You may also hand-deliver the election form to the Plan Administrator (your employer), within the 60-day period. If hand-delivered, your election is considered to have been made on the date that it is received.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage. You do not have to send any payment with your election form. Important information about paying for COBRA coverage is included below under the heading, "Cost of COBRA Coverage." (Information is also provided below about a special second election period for certain individuals eligible for Federal Trade Adjustment Assistance.)

If you reject COBRA coverage before the due date of the election form, you may change your mind as long as you furnish a completed election form before the end of the 60-day election period. However, if you do this, COBRA coverage will begin on the date you furnish the election form and not on the date that you lost coverage under the terms of the Plan as a result of the qualifying event.

Special Considerations in Deciding Whether to Elect COBRA Coverage

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under a federal law known as HIPAA that applies to most group health plans. First, if you have more than a 63-day gap in health coverage, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans. Election of COBRA may help you not have a gap in your health coverage. Second, if you do not elect and take COBRA coverage for the maximum time it is available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions. Finally, you should take into account that HIPAA provides for special enrollment rights. Under HIPAA, individuals have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after group health coverage under your employer's group health plan ends because of a COBRA qualifying event. You will also have

the same special enrollment right at the end of COBRA coverage if you take COBRA coverage for the maximum time it is available to you.

How Long Does COBRA Coverage Last?

As explained above, COBRA coverage is a temporary continuation of group health coverage. The COBRA coverage periods described below are maximum coverage periods. You should keep in mind that COBRA coverage can end early, as explained later under the heading, "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

End of Employment or Reduction of Hours

When the qualifying event is the end of employment (except for gross misconduct) or the reduction of the employee's hours of employment, COBRA coverage generally can be continued for up to 18 months from the date of the qualifying event. There are two ways in which this 18-month period can be extended, described below under the heading "Extension of the 18-Month Period of COBRA Coverage."

Employee's Medicare Entitlement Followed by End of Employment or Reduction of Hours

When the qualifying event is the end of employment (except for gross misconduct) or the reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before one of these qualifying events, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage because of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates (for reasons other than gross misconduct), COBRA coverage under the group health plan for the employee's spouse and dependent children who lost coverage as a result of the employee's termination can last up to 36 months after the date of Medicare entitlement, which is 28 months after the qualifying event.

Employee's Death, Entitlement to Medicare, Divorce, Legal Separation, or Child's Loss of Dependent Status

When the qualifying event is the death of the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child under the terms of the group health plan, COBRA coverage can last for up to 36 months from the date of the qualifying event.

Extension of the 18-Month Period of COBRA Coverage

The 18-month maximum period of COBRA coverage described above when the qualifying event is the end of employment (except for gross misconduct) or reduction of hours, may be extended if: (1) a qualified beneficiary is disabled or (2) a second qualifying event occurs. You must notify the Plan Administrator of a disability or of a second qualifying event in order to be eligible to extend the period of COBRA coverage. Failure to provide notice will end the right to the extension. The opportunity to extend COBRA coverage does not apply if the original qualifying event resulted in up to 36 months of COBRA coverage. The extensions described below can end early as explained under the heading "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Disability Extension of the 18-Month Period of COBRA Coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled, all of the qualified beneficiaries in your family may be entitled to receive an extension of up to an additional 11 months of COBRA coverage, for a total maximum of up to 29 months. To receive the extension, notice of the disability must be properly given as described below. Also, the disability must have started at some time before the 61st day after the employee's end of employment (except for gross misconduct) or

reduction of hours, and the disability must last at least until the end of the original period of COBRA coverage.

You Must Provide Notice of the Disability

The disability extension is available only if you notify the Plan Administrator of the Social Security Administration's determination of disability. Your notice must be given within 60 days after the latest of: (1) the date of the Social Security Administration's disability determination, (2) the date of the covered employee's end of employment or reduction of hours, or (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the group health plan as a result of the covered employee's end of employment or reduction of hours. You must also provide this notice within 18 months after the covered employee's end of employment or reduction of hours in order to be entitled to a disability extension.

To provide this notice, you must send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within both the 60-day period and the 18-month period described in the preceding paragraph. You must use an appropriate envelope with correct postage and the correct address. Any additional procedures required by the Plan Administrator are attached.

If your notice is not properly and timely provided within both the 60-day and 18-month periods as described above, you will lose your right to a disability extension of COBRA coverage.

After your notice has been received, you may be required to provide additional information. For example, you may need to provide a copy of the Social Security Administration's determination of disability.

Notice of a disability can be given by the employee or former employee who is or was covered by the group health plan, by a qualified beneficiary, or by their representative.

Notice If the Disability Ends

If you receive an extension due to disability, and the Social Security Administration determines that the disability no longer exists, you must notify the Plan Administrator of that fact within 30 days after the date of the Social Security Administration's determination. COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the determination that the qualified beneficiary is no longer disabled. The Plan Administrator has the right to require repayment to the group health plan for all benefits paid after the date COBRA should have ended.

To provide this notice, you should send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within 30 days after the date of the Social Security Administration's determination. You must use an appropriate envelope with correct postage and the correct address. Note that it is to your advantage to send this notice earlier than 30 days since COBRA coverage will terminate retroactively to the date it should have ended as explained above. Providing the notice early will help avoid retroactive COBRA termination and the possibility that you will need to repay the group health plan for expenses incurred after the date COBRA should have ended. Any additional procedures required by the Plan Administrator are attached.

Second Qualifying Event Extension of the 18-Month Period of COBRA Coverage

An extension of COBRA coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or 29 months in the case of a disability extension) following the covered employee's end of employment or reduction of hours. The

extension is up to 18 additional months, and the maximum amount of COBRA coverage available when a second qualifying event occurs is up to a total of 36 months. To receive the extension, notice of the second qualifying event must be properly given as described below. The second qualifying events may include the death of the employee or former employee who is or was covered by the group health plan, such employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation from such employee, or a dependent child ceasing to be eligible for coverage as a dependent under the terms of the group health plan. These events can be a second qualifying event only if the second event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred.

You Must Provide Notice of the Second Qualifying Event

This extension due to a second qualifying event is available only if you notify the Plan Administrator that a second qualifying event has occurred. Your notice must be given within 60 days after the later of: (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would lose coverage under the terms of the group health plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the group health plan).

To provide this notice, you must send a written communication to the Plan Administrator whose address is shown at the end of this explanation about COBRA, or you may call the Plan Administrator at the telephone number provided and speak to someone. If mailed, your notice must be postmarked within the 60-day period described in the preceding paragraph. You must use an appropriate envelope with correct postage and the correct address. Any additional procedures required by the Plan Administrator are attached.

If your notice is not properly and timely provided within the 60-day period described above, you will lose your right to an extension of COBRA coverage due to a second qualifying event.

After your notice has been received, you may be required to provide additional information. For example, you may need to provide a copy of a divorce decree, a death certificate, or a school transcript.

Notice can be given by the employee or former employee who is or was covered by the group health plan, by a qualified beneficiary, or by their representative.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

The coverage periods described above are maximum coverage periods. COBRA coverage will automatically terminate before the end of the maximum coverage period if:

(1) Any required premium is not paid in full on time;
(2) A qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. You should provide notice if this other coverage begins, as explained below;
(3) A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both), after electing COBRA. You should provide notice if Medicare entitlement occurs, as explained below;
(4) The employer ceases to provide any group health plan for its employees; or
(5) In the case of a disability extension, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled. You should provide notice if the Social Security Administration makes this determination, and you must do this no later than 30 days after the date of the determination (sooner if possible). See the explanation above under the heading, "Notice If the Disability Ends."

In addition to the above situations that would cause the COBRA maximum coverage period to end early, COBRA coverage will also end for any reason that the group health plan would terminate the coverage of a participant or beneficiary who is not receiving COBRA (such as for fraud or misrepresentation).

Notices to be Provided by Qualified Beneficiary if COBRA Ends Early Due to Other Group Health Plan Coverage or Medicare Entitlement

COBRA coverage will terminate (retroactively if necessary), as of the date it should have ended as allowed by COBRA, even if you have not provided the notices requested of you above in this Termination of COBRA Coverage section. You may have to repay all benefits that were paid by the group health plan for expenses incurred after the date COBRA should have terminated. So that you will not be put in this position, you should notify the Plan Administrator as soon as possible if a qualified beneficiary becomes covered by another group health plan as described in (2) above, entitled to Medicare benefits as described in (3) above, or ceases to be disabled, as described in (5) above. You may notify the Plan Administrator in writing or by phone at the address and phone number given at the end of this explanation. Any additional procedures required by the Plan Administrator are attached.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay for the entire cost of COBRA coverage, plus an administrative fee. The amount may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated group health plan participant or beneficiary who is not receiving COBRA coverage. You will be notified of the cost in your COBRA election materials. The amount of your COBRA premiums may change from time to time and will most likely increase over time. (Information is also provided below about special rules for certain individuals who may be eligible for a tax credit. Refer to the heading "Health Care Tax Credit.")

Paying for COBRA Coverage

First Payment for COBRA Coverage

If you elect COBRA, you do not have to make a payment when you send in your COBRA election. However, you must make your first payment for COBRA coverage no later than 45 days after the date you elect COBRA. (The date you elect COBRA is the date your COBRA election form is postmarked, if mailed; otherwise, the date your election is received at the office of the Plan Administrator.) If you do not make your first payment for COBRA coverage in full within 45 days after the date of your COBRA election, you will lose all COBRA rights under the group health plan. When mailed in an appropriate envelope with the correct postage amount and proper address, a payment is considered to have been made on the date that it is postmarked. Mailed payments should be sent to the Plan Administrator at the address shown at the end of this explanation. You may also hand-deliver payment to the office of the Plan Administrator. If hand-delivered, payment is considered made on the date it is received. You will not be considered to have made any payment if a check you write is returned for insufficient funds or if your payment is not delivered.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the group health plan would have otherwise terminated, up through the time you make the first payment. You are responsible for making sure that the amount of your first payment is correct. You should contact the Plan Administrator as shown at the end of this explanation to confirm the correct amount of your first payment.

Claims for reimbursement will not be paid until you have elected COBRA and made the premium payment.

Monthly Payments for COBRA Coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of coverage. These monthly payments are due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before its due date, your coverage will continue for that month without any break. You are responsible for making sure that your premium payments are made on time. You will not be given notices of payments that are due. When mailed in an appropriate envelope with the correct postage amount and proper address, a payment is considered to have been made on the date that it is postmarked. Mailed payments should be sent to the Plan Administrator whose address is shown at the end of this explanation about COBRA. You may also hand-deliver the payment to the office of the Plan Administrator. If hand-delivered, payment is considered made on the date it is received. You will not be considered to have made any payment if a check you write is returned for insufficient funds or if your payment is not delivered.

Grace Periods for Monthly Payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment, but your coverage is subject to being suspended as explained below.

If you make a monthly payment after its due date but before the end of the 30-day grace period for that month, your health coverage may be suspended as of the first day of the month when payment was due. Coverage will be retroactively reinstated (going back to the first day of the month) when the payment for that month is received. Any claim you submit for reimbursement while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you do not make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage.

Other Individuals Who May be Qualified Beneficiaries

A child who is born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary if the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is timely enrolled in the group health plan, whether through special enrollment or annual enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. The child must meet all other requirements for coverage and enrollment under the plan.

Special Rules for Federal Trade Adjustment Assistance

Special COBRA rights apply to employees who lost health coverage associated with their employment being adversely affected by international trade and who qualify for Trade Adjustment Assistance or Alternative Trade Adjustment Assistance. These employees are entitled to a second opportunity to elect COBRA, if they did not elect it during the initial 60-day election period. The second election period begins on the first day of the month in which you become eligible for trade adjustment assistance (or would be eligible except for the requirement to exhaust unemployment benefits). The second COBRA election period can last for up to 60 days, but the election must also be made within the six months immediately after the date group health coverage was originally lost. If you elect COBRA coverage during the second election period, it is effective on the first day of the second election period and not on the date coverage was originally lost. However, the maximum period of COBRA coverage is still measured from the date of the original qualifying event.

Healthcare Tax Credit

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (as described in the preceding heading) and for certain retired employees who are

receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage.

If you have questions about these new tax provisions, you should call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

If You Have Questions

Questions about your rights under COBRA should be addressed to the Plan Administrator whose address and telephone number are provided at the end of this explanation. Questions about your rights under the Plan should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

Keep the Plan Informed of Address Changes

In order to protect your and your family's rights, you should update any changes in your address and the addresses of family members. Updates should be mailed to the Plan Administrator whose name and address are provided at the end of this information about COBRA. You should also keep for your records a copy of any notices you send about COBRA.

Plan Administrator

The name and address of the Plan Administrator is:
City of Forney
101 East Main Street
Forney, TX 75126
972-564-7315

Continuation coverage under COBRA is at all times subject to the rules and regulations under COBRA. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

VIII. Definitions

a. **Benefit Year:** The 12-month period used by the Group Health Plan for the measurement of satisfaction of the annual deductible amount for the Group Health plan. The Benefit Year is usually the calendar year, but refer to the Group Health Plan, which may use a period other than the calendar year to measure satisfaction of the annual deductible amount.

b. **Claims Administrator:** The Claims Administrator is Flores & Associates, LLC, 1218 S Church Street, Charlotte, NC 28203. The toll free number for the Administrator is: 800-532-3327.

c. **Code:** The Internal Revenue Code of 1986, as amended.

d. **Entity:** City of Forney and any successor thereto who assumes the Plan.

e. **Covered Person**: An Eligible Employee or Eligible Dependent, as set forth in Section III who is covered by this Plan.

f. **ERISA:** The Employee Retirement Income Security Act of 1974, as amended.

g. **Group Health Plan:** The principal program of health benefits maintained by the Entity for its employees, their spouses and eligible dependents, and which provides major medical type benefits through a group insurance policy or policies.

h. **Medical Care Expenses.** Expenses incurred by a Covered Person for medical care as defined in Code § 213, but only to the extent all or a portion of such Expenses are payable by the Group Health Plan.

i. **Named Fiduciary:** The Entity.

j. **Participant:** An Eligible Employee who participates in the Plan.

k. **Plan:** City of Forney Section 105 Health Reimbursement Plan, described herein.

l. **Plan Administrator**: The Entity.

m. **Plan Year:** 01/01/2021-12/31/2021

IX. Additional Information

Plan Administration and Authority of Plan Administrator
The operation of the Plan shall be under the control of the Plan Administrator, which shall carry out the Plan in accordance with its terms and intent, for the exclusive benefit of participants and beneficiaries. The Plan Administrator shall have full power and discretion to administer the Plan in all of its details, including but not limited to the power to (a) make and enforce rules as the Plan Administrator believes is necessary for the proper and efficient administration of the Plan, (b) interpret the Plan, including any ambiguous terms and including supplying any provisions that may have been omitted, said interpretation of the Plan Administrator being conclusive and binding on all persons claiming benefits under the Plan, (c) decide all questions of fact and/or law concerning the Plan and its administration, and the eligibility of any person to participate and receive benefits, and (d) appoint agents, counsel, or anyone else as may be required or helpful to administer the Plan.

The Plan Administrator has the authority to allocate among its members or employees any of its duties and responsibilities under the Plan, or the Plan Administrator may designate persons other than members or employees to carry out any of its duties and responsibilities.

Participation by Other Employers
As permitted by the Entity, any employer which is treated as a single employer with the Entity may become a participating employer under the Plan.

Amendment and Termination

The Entity reserves the right to amend, modify, revoke or terminate the Plan at any time and in any manner, without the consent of any participant or beneficiary. The authority to amend or terminate the Plan rests with the Entity and any duly authorized officers or other authorized representatives of the Entity. The persons with authority to amend or terminate the Plan include: Corp Secretary>. An amendment shall be in writing.

Compliance with Federal Law

This Plan will comply with any applicable Federal law, including but not limited to any requirement under ERISA Sec. 609 to provide benefits in accordance with the terms of any qualified medical child support order. This Plan shall be operated in accordance with all applicable Federal laws, though such law may not be referenced herein.

X. Required Information for Summary Plan Descriptions

The above sections of the Plan (the plan document) and the information provided below (the summary plan description) are combined into this single document, intended to provide easy-to-understand explanations of the Plan's provisions. It is intended that the Plan be administered in accordance with all relevant laws. To the extent that any provision is contrary to applicable law (or is not included in the Plan), that law will govern as to its specific requirements.

Name of the Plan
City of Forney Section 105 Health Reimbursement Plan.

Eligibility and Benefits Under the Plan
The requirements for eligibility, participation, and benefits are described in the preceding sections. The Plan reimburses limited medical expenses as described above. The procedures governing claims for benefits, for filing claim forms, and requesting an appeal and review of denied claims are described in the preceding sections. Circumstances that may result in ineligibility, loss of benefits, offset, etc. are described in the preceding pages. The previous pages also describe COBRA continuation coverage rights that are applicable if the Entity is subject to COBRA. Participants and beneficiaries can obtain, without charge, a copy of procedures governing qualified medical child support orders.

Employer Identification Number and Plan Number
The identification number assigned to the plan sponsor is 75-6003089

The Plan number is: 501

Plan Sponsor/Plan Administrator
City of Forney
101 East Main Street
Forney, TX 75126
972-564-7315

See the above Section IX regarding the discretionary authority of the Plan Administrator over the Plan and its operation. The Plan Administrator has delegated the function of claims administration to the entity named below.

Claims Administrator
Flores & Associates, LLC
Post Office Box 31397
Charlotte, NC 28231-1397
(704) 335-8211

Type of Plan
The Plan is authorized under Section 105(h) of the Internal Revenue Code; the Plan is also a welfare plan under ERISA. It reimburses specific medical expenses as described herein.

Plan's Records
Records are maintained for a Plan Year for the maximum number of years required by law.

Acceptance of Legal Notice
The Plan is a legal entity. Legal notices may be filed with, and legal process served as provided below. Service of legal process may also be made on the Plan Administrator.
City of Forney
101 East Main Street
Forney, TX 75126
972-564-7315

Future of the Plan
City of Forney intends to continue this Plan indefinitely. However, the Entity reserves the right to change or terminate the Plan at any time without the consent of any participant or beneficiary. The Entity or any authorized officer or representative of the Entity can make changes to or terminate the Plan. The following officer(s) or representatives of the Entity may change or terminate the Plan: Corp SecretaryCorporate Secretary. Participants will be appropriately notified of any changes or termination.

Cost of Coverage and Funding of the Plan
The Employer pays the full cost of the Plan. There are no employee contributions except as may be required to continue coverage under this Plan by electing COBRA, in which case, any employee contribution shall be made on an after-tax basis. All amounts paid as benefits under this Plan shall be paid from the general assets of the Entity.

XI. Rights of Employees Under ERISA

All Participants in the Plan are entitled to certain rights and protections under ERISA. You are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and any union halls, all documents governing the plan, including any insurance contract or collective bargaining agreement, and a copy of the latest annual report (if one is required) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefit Administration). You may obtain, upon written request to the plan administrator, copies of the above, as well as an updated summary plan description. The administrator may make a reasonable charge for copies. You may receive a summary of any annual financial report that ERISA may require.

Continue Group Health Plan Coverage
If your Entity is subject to COBRA, you may have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the terms of the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review prior provisions in this document on the rules governing your COBRA continuation coverage rights.

If covered by certain sections of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you may be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. The Plan will comply with any requirements that may apply under HIPAA.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon certain people who are responsible for the operation of the employee benefit plan. The people who operate your plan may be "fiduciaries"; and if they are fiduciaries, they have a duty to operate the plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union (if any), or

any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules that are described in the preceding pages under the Claims section.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan (if an annual report is required) and you do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, provided that you have followed the claim and appeal procedure described at Section V above. If you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court, but you must follow the claims and appeals procedure described by the plan first. If it should happen that plan fiduciaries misuse the plan's money (if the plan is considered by the law to have money) or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Newborns' and Mothers' Health Protection Act of 1996
You should be aware that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

XII. Health Insurance Portability and Accountability Act (HIPAA)

A. Governing Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose individually identifiable health information that is protected by HIPAA (hereafter "protected health information" or "PHI"). The following HIPAA definition of PHI applies to this Plan.

B. Protected Health Information

Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provisions of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected health information includes information of persons living or deceased. The Plan Sponsor shall have access to PHI from the Plan only as permitted herein or as otherwise required or permitted by HIPAA.

C. Provision of Protected Health Information to Plan Sponsor

(1) Permitted Disclosure of Enrollment/Disenrollment Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(2) Permitted Uses and Disclosure of Summary Health Information. The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan. "Summary Health Information" means: information that: summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a group health plan; and from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(3) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in subparagraph C.(5) below and obtaining written certification as further described in Section D. below**,** the Plan (or a health insurance issuer or HMO on behalf of the Plan) may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan and having to do with payment and health care operations, including but not limited to activities such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

(4) Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

(5) Conditions of Disclosure for Plan Administration Purposes. Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan) Plan Sponsor shall:

(a) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
(b) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.
(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
(g) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
(h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
(i) 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, 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.
(j) Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware. For this purpose, security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

(6) Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall allow the following to access PHI: President, Vice-President and Office Manager. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures or other special discipline procedure that may be created by the Privacy Officer.

Further, as of the date that the HIPAA Security Rules apply to this Plan, Plan Sponsor will ensure that the above provisions related to Adequate Separation are supported by reasonable and appropriate security measures to the extent that the designees above have access to electronic PHI.

D. Certification of Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan) shall disclose PHI to the Plan Sponsor only upon the receipt of a certification from the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in subparagraph C.(5) above, "Conditions of Disclosure for Plan Administration Purposes."

ADOPTION OF THE
City of Forney
SECTION 105 HEALTH REIMBURSEMENT PLAN

The person whose signature appears below is properly authorized by _____ to adopt the _____Section 105 Health Reimbursement Plan and by his or her signature below does adopt said plan on behalf of the Entity, effective as of _____, 20_____.

This the _____ day of _____, _____.

City of Forney

By: _____

Title: _____