

**The City of Mandan
Health Reimbursement Plan**

Plan Document

Effective Date of the Plan

01/01/2016

Table of Contents

<u>Section</u>	<u>Description</u>
1.0	Plan Definitions
2.0	Purpose of the Plan
2.1	Purpose of the Plan
3.0	Benefits of the Plan
3.1	Benefits of the Plan
3.2	Benefit Account
3.3	Benefit Cost
3.4	Maximum Benefit
3.5	Changes to Benefit Minimum and Maximum
4.0	Plan Eligibility
4.1	Plan Eligibility
4.2	Coordination with HSA
4.3	Plan Entry Date
4.4	HIPAA Portability
5.0	Plan Participation
5.1	Plan Participation
5.2	Term of Participation
6.0	Plan Contributions and Reimbursements
6.1	Plan Contributions
6.2	Claim Substantiation
6.3	Reimbursements of Eligible Expenses
6.4	Revocation/Modification of Plan Contributions
6.5	Non-Standard Plan Contributions
6.6	Nondiscrimination
6.7	Forfeiture of Unpaid Benefits
6.8	Cash-out Exception
7.0	Change in Life Status
7.1	Change in Life Status
8.0	Plan Administration
8.1	Plan Administrator
8.2	Plan Administration
8.3	Denial of Benefits
8.4	Indemnity
9.0	COBRA Continuation Coverage
9.1	COBRA Description
9.2	Notification Requirements
9.3	Coverage Type
9.4	Acceptance Procedure
9.5	Premium Contributions
9.6	COBRA Termination
10.0	Miscellaneous
10.1	Amendment and Plan Termination
10.2	No Employment Contract
10.3	Nonassignability

10.4	Facility of Payment
10.5	Required Information
10.6	Assumed Compliance
10.7	Plan Funds
10.8	Severability
10.9	Certain Conflicts
10.10	Construction
10.9	Applicable Laws
11.0	Adoption of the Plan
11.1	Adoption of the Plan

Section 1 Definitions

1.0 Definitions - The following definitions shall be used in reference to this document.

1.1 "Affiliated Company" - means another entity as described in the Code (Section 414(b), (c), (m) or (o)) that receives the Employer's consent to participate in the Plan.

1.2 "Annual Salary Reduction" - means the amount a Participant voluntarily elects to reduce his income to pay for Benefits under the Plan.

1.3 "Benefits Account" - means an administrative account established to track a Participant's pretax contributions and payments for Plan Benefits.

1.4 "COBRA" - means the Consolidated Omnibus Budget Reconciliation Act of 1985 and its amendments.

1.5 "Code" - means the Internal Revenue Code of 1986 and its amendments.

1.6 "Component Plan" - means any one of the following plans in effect during the Plan Year:

- a) The City of Mandan Medical Plan; or
- b) The City of Mandan Dental Plan.

1.7 "Contributions" - means Employee (and/or Employer) funds used to pay Benefits under the Plan.

1.8 "Dependent" - means all legally married opposite (and same) sex spouses regardless of state of residence, related child or other individual who is defined as a dependent in Section 152 of the Code. Dependents may receive benefits through the Plan but they cannot be Participants in the Plan.

1.9 "Effective Date" - means the first day of the Plan Year in which Benefits can be received under the Plan. The City of Mandan Health Reimbursement Plan's Effective Date is 01/01/2016.

1.10 "Eligible Employee" or "Employee" - means an employee of the Employer meeting the eligibility requirements of the Plan. Employees may be common law employees, leased employees described in Section 414(n) and full-time life insurance salesmen [as defined in section 7701(a)(s0)]. The term may also reference former employees (or their covered dependents) who have elected to continue coverage under this Plan as allowed by COBRA (if and when COBRA applies to the Employer). Self-employed individuals are not treated as employees for purpose of Section 125. Sole proprietors, partners, directors of corporations and two-percent (or more) shareholders of an S corporation are not considered to be Employers under Section 125 and may not participate in the Plan.

1.11 "Employer" - means City of Mandan and Affiliated Company.

1.12 "Enrollment Form" - means a copy of the Health Reimbursement Plan Enrollment Form (to be completed by an Eligible Employee and submitted to the Plan Administrator in a timely fashion).

1.13 "Enrollment Period" - means the time frame establish by the Employer in which the Eligible Employee may submit an Enrollment Form to the Plan Administrator.

1.14 "Entry Date" - means the first day the Employee is enrolled on the Plan.

1.15 "ERISA" - means the Employee Retirement Income Security Act of 1974 and its amendments.

1.16 "Expense" - In general, Expense means an amount paid or incurred for services/products that are not covered under a Component Plan and are designed for the purpose of maintaining the participant's health (as described in Section 213(d) of the Code) or cosmetic surgery as a result of an illness or injury. For Employees enrolled in an HSA (or who have a Spouse enrolled in an HSA), this Plan has three options (Section 4.2) that limit FSA reimbursement based upon type of expense or the person who incurred the Expense. Notwithstanding the foregoing, expenses attributable to long term care and premiums for individual insurance are not "Expenses" for purposes of this Plan.

1.17 "FMLA" - means the Family Medical Leave Act of 1993, as made from time to time.

1.18 "Grace Period" - Under IRS Ruling 2005-42, Employees are eligible to submit and receive reimbursement for receipts with a date of service that is within a 2 1/2 month period after the end of the Plan Year. This grace period is optional for FSA plans and Employers decide if it is implemented. The Plan shall apply the maximum 2 1/2 month extension, accepting (and reimbursing) claims with dates of service during the extension. The Post Plan Year Receipt Submission Period will begin the day after the completion of the extension.

1.19 "HDHP" - means a High Deductible Health Plan as described under Code Section 223.

1.20 "HEART" - means the Heroes Earnings Assistance and Relief Tax Act of 2008.

1.21 "Highly Compensated Individual" - means an Employee of the Employer defined by Code Section 105(h)(5).

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

1.23 "HSA" - means a Health Savings Account as established by Code Section 223. These accounts are individual accounts owned by the Employee and administered by a qualified trustee/custodian. In general, Employees are not permitted to enroll in a Standard Health FSA. However, by limiting the benefits available or limiting eligible Dependents, Employees may select from three options (explained in Section 4.2) meeting the coordination between HSA and FSA guidelines.

1.24 "IRS Ruling 2005-42" - If implemented, IRS Ruling 2005-42 extends the deadline for reimbursement of health and

dependent care expenses up to 2 1/2 months after the end of the Plan Year. Claims with a date of service within this 2 1/2 month extension would be reimbursed as if they occurred during the Plan Year. (This cannot be combined with IRS Notice 2013-71).

1.25 "IRS Notice 2013-71" - If implemented, IRS Notice 2013-71 allows Participants to "roll over" up to \$500.00 of unused funds from their year-end HRP Benefit Account to the next Plan Year. (This option cannot be combined with IRS Ruling 2005-42). The Plan has elected not to implement this 'roll over' option.

1.26 "Key Employee" - means an Employee described in Code Section 414(i)(1).

1.27 "Participant" - means an Eligible Employee (and covered Dependents) who has elected to enroll in the Plan, completed and submitted the appropriate paperwork to the Plan Administrator (in a timely fashion) and met the appropriate Waiting Period.

1.28 "Pay Period Reduction" - means the amount a Participant's income is reduced each scheduled pay period.

1.29 "Plan" - means The City of Mandan Health Reimbursement Plan adopted by the Employer exclusively for the benefit of Eligible Employees.

1.30 "Plan Administrator" - means City of Mandan or other Employer appointed person, committee or organization to administer the Plan.

1.31 "Plan Year" - means the 12 consecutive month period commencing on the Effective Date and each anniversary thereof.

1.32 "Post Plan Year Receipt Submission Period" - means the 3 month period after the end of the 2 1/2 month extension (as provided by IRS Ruling 2005-42) in which Participants may submit eligible receipts.

1.33 - "PPACA" - means the Patient Protection and Affordable Care Act of 2010.

1.34 "Qualified Beneficiary" - means a Participant within the meaning of Section 4980B(g).

1.35 "Salary Reduction Agreement" - means the Employee's voluntary authorization for the Employer to reduce the Employee's compensation to pay for Benefits provided under the Plan.

1.36 "Service Date" - means the day eligible services were received by the Participant or covered Dependent.

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

1.38 "Waiting Period" - means the 3 month time frame commencing from the date of hire to the Employee's Entry Date into the Plan.

Section 2 Purpose of the Plan

2.1 Purpose of the Plan - The City of Mandan Health Reimbursement Plan (HRP) is adopted by City of Mandan to be effective 01/01/2016. The purpose of the Plan is to offer Eligible Employees the ability to be reimbursed for qualified Expenses excluded under the Component Plan(s). City of Mandan intends that the Plan qualify as a "medical reimbursement plan" as described under Section 105 (h) of the Code. Benefits received by participating Employees shall be eligible for exclusion from the Employee's income for federal income tax purposes as stated under Code Section 105(h). Employees electing not to enroll in the City of Mandan Health Reimbursement Plan will pay for excluded Component Plan Expenses on an after-tax basis. This Plan Document was written to meet the requirements of a Health FSA as detailed in the August 6, 2007 Proposed Regulations (26 CFR Part I) and PPACA.

Section 3 Benefits of the Plan

3.1 Benefits of the Plan - Eligible Employees enrolling in the City of Mandan Health Reimbursement Plan may reduce their annual compensation (by an amount not to exceed the Plan Maximum), establishing a Benefit Account from which the Employer shall reimburse the Participant for eligible Expenses. The account funds used to pay for eligible Expenses shall be excluded from the Participating Employee's income for federal tax purposes. The Employee's Annual Salary Reduction may only be changed if the Employee and/or Dependent experience a "Change in Life Status" (as defined in Section 7.1).

3.2 Benefit Account - The Employer will create administrative accounts for each Participating Employee and debit the accounts by the designated Pay Period Reduction on each scheduled pay period. As Participants submit eligible Expenses, the Plan Administrator shall on a routine basis (at the discretion of the Plan Administrator) reimburse the Participant and credit their Benefit Account. Participants are eligible for immediate reimbursement of their Annual Salary Reduction amount even though there may not be sufficient funds available in their Benefit Account. All funds remaining in a Participant's Benefit Account at the end of the Post Plan Year Receipt Submission Period, shall be forfeited.

3.3 Benefit Cost - Prior to the Participant's Entry Date, the Participant shall designate an annual Salary Reduction Amount. The Participant authorizes the Employer to reduce their income by the designated amount, establish a Benefit Account to pay for submitted eligible Expenses. The Benefit Cost shall be the Participant's Annual Salary Reduction Amount. This amount will remain constant throughout the Plan Year and can only be changed if a Change in Life Status is experienced.

3.4 Maximum Benefit - Prior to the Plan Year Effective Date, the Employer shall designate the maximum benefit amount (not to exceed the \$2,500.00 limit established by PPACA). The 2016 Maximum Benefits shall be \$2,500.00 and will remain constant until the time an amendment changes the value. The Employer shall notify Eligible Employees of the change in the Maximum Benefit prior to the first day of the Plan Year. Employees are eligible for their Annual Salary Reduction amount regardless of the Contribution amounts on or after their Entry Date (or the date the Plan was adopted by the Employer if later than the Entry Date). This right to the full amount shall be known as the "Uniform Coverage" rule.

Employees enrolling at times other than the beginning of the Plan Year will not be subject to pro-rationing of the Maximum Benefit. These Employees are eligible for the Maximum Benefit regardless of their Entry Date.

3.5 Changes to Benefit Minimum and Maximum - The Employer may change the Benefit Minimum and Benefit Maximum prior to the start of a Plan Year. Employees will be notified of the Benefit Minimum and Benefit Maximum in writing prior to start of the Plan Year.

Section 4 Plan Eligibility

4.1 Plan Eligibility - Employees become eligible to participate in the Plan upon meeting the appropriate following criteria and submitting an Enrollment Form in a timely fashion.

- a) Newly hired Employees are eligible to participate in the Plan after meeting the 3 month Plan Waiting Period.
- b) Active Employees (those that have already met the waiting period) are eligible to participate in the Plan on the first day of the Plan Year.
- c) Former Employees who's employment was terminated (either voluntary or involuntary) and are subsequently rehired within thirty days (from date employment is terminated) shall not have to meet the Plan Waiting Period. If the Employee is rehired within the same Plan Year, such Employees shall not be entitled to submit a new Enrollment Form for such Plan Year but instead shall have reinstated (as of the date of reemployment) the same coverage under the Component Plans as was in effect at the time he ceased to be a Participant. Former Employees rehired after thirty days shall need to meet the requirements of a newly-hired Employee [described in 4.1(a)].
- d) Former Employees who are rehired in a Plan Year beginning after the Plan Year in which his participation ended shall become a Participant as of the date of his reemployment provided that the Employee files a new election form for such Plan Year with the Plan Administrator as provided in Section 5.1.
- e) Employees who took an unpaid leave of absence under FMLA and returns to work may be eligible to participate without meeting the Plan Waiting Period. If the Employee elects to participate in the Plan, and unpaid Plan Contributions are due for any or all time while on FMLA leave, the Employer has the right to deduct the amount for applicable premiums on an after-tax basis from the Employee's income, subject to Section 6.5.
- f) Employees who are absence on account of military Service covered by USERRA shall not have to meet the Plan Waiting Period when they return to employment.

4.2 Coordination with HSA - In general, Employees (or Dependents) enrolled in an HSA are not eligible to participate in a Standard Health FSA plan because of the potential for the submission of one claim to two plans for reimbursement. This Plan offers three options to allow Employees to participate in the FSA but on a limited basis.

- a) A Limited (Dental/Vision/Preventive Care) Health FSA option - For Employees enrolled in an HSA, benefits will be limited to dental, vision and preventive care expenses found under Code Section 213(d).
- b) Employee Only FSA option - Employees who have a spouse (and children) enrolled in a HDHP and making contributions towards an HSA may enroll in this option but would not be eligible for reimbursement of Dependent claims.
- c) Employee Plus Children Health FSA - Employees who have a spouse (but not dependent children) enrolled in a

HDHP and making contributions towards an HSA may enroll in this option but would not be eligible for reimbursement of Spouse's claims.

4.3 Plan Entry Date - Employee's Plan Entry Date will be the first day after meeting the Plan Eligibility requirements in section 4.1. Annual Salary Reduction will begin on the first pay period after eligibility into the Plan (or the date the Company can reasonably make the reduction from the payroll system).

4.4 HIPAA Portability - Notwithstanding any other provisions in Section 4, any Employee considered eligible under the Health Insurance Portability and Accountability Act of 1996 shall be eligible to enroll in the Plan and have a Plan Entry Date determined by the Plan Administrator.

Section 5 Plan Participation

5.1 - Plan Participation - Eligible Employees become Plan Participants by completing (and signing) the appropriate Enrollment Form and submitting it to the Plan Administrator prior to the Employee's Plan Entry Date (or within ten working days after the Employee's Plan Entry Date if the Plan Entry Date is immediate upon hire, rehire, return from a FMLA leave or return from military service covered by USERRA). The Enrollment Form shall provide the elected Annual Salary Reduction Agreement authorizing the Employer to withhold a designated amount from the Participant's compensation. Prior to the first day of any new Plan Year, eligible Employees must submit a completed Enrollment Form designating a Salary Reduction Amount for the new Plan Year. If the Employee does not submit a completed Enrollment Form in the time frame explained above, he will be ineligible until the next Plan Year to enroll in the Plan.

5.2 Term of Participation - Employees meeting the Plan Participation requirements shall remain covered by the Plan until the earliest of the following

- a) The last day of the Plan Year (or Grace Period if elected);;
- b) The day after the death of the Employee, subject to Section 9;
- c) The day separation of employment (voluntary or involuntary) occurs;
- d) The day the Employee ceases to be an Eligible Employee;
- e) The day the Participant who experienced a Change in Life Status revokes participation under the Plan;
- f) The day the Participant fails to make a contribution, unless the Participant is on an unpaid FMLA leave; or
- g) The day the City of Mandan Health Reimbursement Plan terminates.

Section 6 Plan Contributions and Reimbursements

6.1 Plan Contributions - Plan Participants agree to reduce their annual salary (through a Salary Reduction Agreement found on the Enrollment Form) by a voluntary designated amount, which is to be used by the Employer to pay for submitted eligible Expenses. The Employer shall be responsible for the accounting of the Participant's Benefit Accounts. The Employer may maintain the funds in a general account (or any account that is deemed in the best interest of the Plan).

Participant Plan Contributions will be credited towards the Participant's Benefit Account in equal amounts (changing only if a Change in Life Status occurs) throughout the Plan Year, subject to the Participant's termination of coverage under Section 5.2.

6.2 Claims Substantiation - Flexible Spending Arrangements have specific rules regarding eligible claims and the procedures needed prior to reimbursing a claim. With this Plan, a qualified staff member will review all claims submitted to ensure they include:

- a) The Employee's Name;
- b) The name of the person that received the services (or products) and if they are eligible to receive benefits under the

Employee's Plan;

- c) Review the service or product and determine if it is an eligible expense as detailed in Section 213(d);
- d) Review the date the service (or product) was rendered to ensure it is within the Plan Year, prior to the end of the grace period (if applicable) and after the Adoption of the Plan (in Section 11.1);
- e) Determine if the claim was submitted to the Administrator during the associated Plan Year or its Post Plan Year Receipt Submission Period;
- f) A statement that the claim has not been reimbursed, in the process of being reimbursed or will be submitted for reimbursement to another source (such as FSA, HRA, HSA or insurance plan); and
- g) When applicable, a denial of benefits from the Component Plan.

Claims found to be "invalid" shall be denied and no reimbursement will be given; in part or in full. If information is missing from the claim, the Administrators will notify the Employee of the missing information and state the claim cannot be reimbursed until such information is provided.

6.3 Reimbursements of Eligible Expenses - To receive reimbursement for eligible Expenses, the Participant must submit the actual or photocopy receipt of the provider that performed the services (or sold the product). Once submitted, the Administrator will substantiate the claim. If the claim is deemed valid, it will be reimbursed on a routine basis in a manner dictated by the Employer. Participants submitting Expenses that are denied reimbursement shall be allowed the ability to request a written explanation and arbitration procedure as stated in Section 8.3.

6.4 Revocation/Modification of Plan Contributions - After the Participant's Plan Entry Date, Participants shall not be allowed to revoke or modify their Plan Contributions unless the Employee or covered Dependent experiences a Change in Life Status (as detailed in Section 7.1). Prior to the Participant's Plan Entry Date, the Participant shall be eligible to revoke or modify Plan Contributions. Any change to Plan Contributions requires the Participant to complete a new Enrollment Form and Salary Reduction Agreement.

6.5 Nonstandard Plan Contributions - Participants who experience a COBRA qualifying event (as defined in Section 9.1), are absent on account of military service covered by USERRA or take an unpaid leave of absence under FMLA shall be able to revoke or modify Plan Contributions. Since the Employer can no longer obtain Plan Contributions through payroll reduction, other collection means may become necessary. Participants may elect to continue in the Plan provided the appropriate regulation criteria are met and contributions are made in one of the following methods. Participant Plan Contributions may change to accommodate any Plan Contributions being made by the Employer (plus applicable administration fees).

- a) Prepayment Method - Participants may prepay Plan Contributions. The Employer shall not make prepayments mandatory for the Participant to remain in the Plan.
- b) Pay-As-You-Go Method - The Employer shall allow Participants to make Plan Contributions on a monthly basis or in an agreed upon (and written) voluntary scheduled method between the Participant and the Plan Administrator.
- c) Catch-Up Method - For Participants taking a FMLA leave of absence, the Employer may make Plan Contributions for the Participant and recoup them upon the Participant's return to work.

6.6 Nondiscrimination - The Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility, contributions and Benefits under the Plan. The Plan Administrator may exclude Highly Compensated Individuals from Plan Participation, limit the Plan Contributions made by such employees or other such actions to maintain the integrity of the Plan.

6.7 Forfeiture of Unpaid Benefits - Participants shall forfeit any funds remaining in their Benefit Accounts on the day after the Post Plan Year Receipt Submission Period. Receipts may be submitted until the end of the Post Plan Year Receipt Submission Period but the Service Date must be during the Participant's Term of Participation. Funds remaining in a Participant's Benefit Account may not be transferred or allocated towards another Plan Year (considered as 'deferred compensation' under Section 125). All Participants' Benefit Accounts will have a zero balance following the Post Plan Year Receipt Submission Period.

The Plan Administrator shall utilize forfeited funds for Plan administration expenses. If forfeiture of unpaid Benefits still remain after paying Plan administration expenses, the Plan Administrator shall utilize funds (in compliance with the Code) to benefit all Participants, equally and uniformly.

6.8 Cash-out Exception - With the passage of HEART, employees who are called to active United States military duty for a minimum of 180 days are eligible for a cash-out called a "Qualified Reservist Distribution" (or QRD) of their Benefit Account. Employees with a positive balance (calculated by subtracting paid claims from employee contributions towards the Plan as of

the date of the QRD) shall be eligible for reimbursement of those funds. This is the only allowable situation whereby an employee may be reimbursed for funds in their Benefit Account.

Employees eligible for a QRD must notify the Plan Administrator of their call to active duty and request the QRD prior to the end of the Post Plan Year Receipt Submission Period.

Section 7 Change in Life Status

7.1 Change in Election - A Participant may change his annual Salary Reduction Amount during a Plan Year if the Employee, his spouse or his dependent experiences a Change in Life Status or the plan covering him experiences an increase in premium or a significant change in coverage. If one (or more) of those events occur, the Participant (or dependent) may revoke or alter their Annual Salary Reduction Amount by completing a Change in Life Status Form and submitting it to the Plan Administrator within a timely fashion. One or more of the following events constitutes a Change in Life Status:

- a) Employee gets married, divorced, legally separated or his marriage is annulled;
- b) Adoption, Birth or Death of a Dependent;
- c) Death of the Employee;
- d) Employee or Dependent becomes newly employed or unemployed;
- e) Employee or Dependent's employment goes from part-time to full-time or full-time to part-time;
- f) Dependent spouse/child becomes (or ceases to be) an eligible "dependent" under the Component Plan;
- g) Employee or his spouse has a judgment, decree or order resulting from a divorce, legal separation, annulment or custody change regarding health coverage of a child. Any Qualified Medical Child Support Order (QMCSO) must state the recipient covered by the order and which Component Plan;
- h) A significant change in the Dependent's health care coverage attributable to the Dependent's employment;
- i) Any change between an hourly paid and a salaried position or between a non-bargaining unit position and a bargaining unit position;
- j) An Employee's or Dependent's move to a work location outside the service area of the Component Plan in which the Employee was enrolled prior to the move;
- k) A change in the Dependent's employment status including a change attributable to a strike or lockout, or the commencement of or return from an unpaid leave of absence; or
- l) Employee becomes entitled to Medicare.

Any in an Employee's existing election must be consistent with the Change in Life Status. A change in election must be made no later than thirty (30) days after the date of the Change in Life Status. The Plan Administrator shall determine whether a Change in Life Status has occurred and whether a Participant's change in coverage is consistent with such Change in Life Status.

Section 8 Plan Administration

8.1 Plan Administrator - The Plan Administrator shall be responsible for the administration of the Plan having all rights, powers and duties as set forth in the Plan. The Plan Administrator may delegate any of its duties under this Plan.

8.2 Plan Administration - The following describes the administration duties (but not limited in scope) of the Plan Administrator.

- a) Determine Participant Plan Contribution Amounts on an annual basis (or upon a premium change or significant change in coverage);
- b) Distribute Plan Communications (i.e. Plan Document Summaries, Enrollment Forms, Plan Change/Law Changes and/or other material related to the Plan) to Eligible Employees and Participants;
- c) To interpret the Plan in its discretion including resolving claim ambiguities, inconsistencies or omissions. The determination of the Plan Administrator shall be binding and conclusive upon all persons whomsoever.

- d) The Plan Administrator is authorized and empowered, in its sole and absolute discretion, to promulgate any uniform rules, regulations and schedules of general applicability and to adopt such forms as the Plan Administrator deems necessary in order to carry out the purpose of the Plan;
- e) Review Plan testing to determine if the Plan favors Highly Compensated Individuals, Participants or Key Employees; and
- f) To hire any agent, accountant, attorney or other qualified individual to assist with the interpretation of the Plan and/or assist with the proper administration. Fees for these services shall be paid by the Employer or excess reserves of the Plan.

8.3 Denial of Benefits - If Benefits are denied under the Plan, Participants may submit (in writing) a description of the situation to the Plan Administrator for review. The Plan Administrator will review the claim and make a decision as soon as reasonably possible, but no later than thirty (30) calendar days from the date it receives the written claim. In special circumstances, Plan Administrator may have an extension of this thirty (30) day period. It may take additional time (up to fifteen (15) days) to decide the claim if special circumstances exist, however, to do so, it will tell the Participant in writing what those special circumstances are and the date on which it expects to make its decision. If Plan Administrator takes an extension, it will make its decision as soon as reasonably possible, but no later than fifteen (15) days from the date the Participant is notified of the extension.

If Plan Administrator takes an extension because it needs additional information, it will notify the Participant of the information it needs as soon as reasonably possible, but in no event later than 30 days from the date it received the initial claim. The Participant will have forty five (45) days to provide this information. Plan Administrator will make a decision as soon as reasonably possible, but in no event later than fifteen (15) days after it receives the requested information. The days during which Plan Administrator is waiting for the information from the Participant will not count against either the thirty (30) day initial decision making period or the fifteen (15) day extension period.

Plan Administrator will provide the Participant with written notification of its decision. If the Participant's claim is denied, the notice will identify the specific reasons for the denial, refer to the sections of the Plan upon which its decision was based and inform the Participant of his right to appeal its decision

If the Participant's claim is denied, the Participant may appeal that decision to the Plan Administrator. If the Participant decides to appeal, the Participant's appeal must be made in writing and postmarked within 180 calendar days from the date of written notification from Employee Benefits. As part of the Participant's appeal, the Participant should provide any supporting documentation he may have, including information which was not previously provided to Plan Administrator. The Participant may also review and receive copies of relevant information relating to his claim. Copies will be provided free of charge. For purposes of the Plan, "relevant" information includes documents, records or other information if they were relied upon by the Plan Administrator, as applicable, in the course of making its decision, was submitted, considered or generated upon by the Plan Administrator, as applicable, in the course of its decision making even if they were not actually relied upon by the Plan Administrator, as applicable, in making its decision, or demonstrate compliance with the administrative processes and safeguards established by the Plan to insure that the terms of the Plan have been followed and applied consistently. Requests to review or obtain copies of relevant information must be made in writing and mailed or delivered to Plan Administrator.

If the Participant does not appeal the decision made by the Plan Administrator within thirty (30) calendar days from the date of notification, the Participant will be deemed to have accepted that decision .

The Plan Administrator will review the Participant's final appeal as soon as reasonably possible, but no later than 30 calendar days from the date it receives the Participant's written appeal. If the Participant's appeal is denied, the Plan Administrator's notice will include the specific reasons for the denial, refer to the sections of the Plan upon which its decision was based and inform the Participant of his right to bring an action under Section 502(a) of ERISA.

8.4 Indemnity - The Employer shall agree to indemnify and hold harmless (to the extent permitted by law) any employed, hired, contracted individual or software provider to assist with the implementation and administration of the Plan. In addition, the Employer agrees to pay for any costs of defense or other legal fees.

Section 9 COBRA Continuation Coverage

9.1 COBRA Description - Under COBRA, Employees may have the right to continue under the Plan upon experiencing a "qualifying event." COBRA continuation coverage will only be provided to a "Qualified Beneficiary" only if the Plan Benefit available to that Qualified Beneficiary after the qualifying event is greater than the Plan Contributions that he would have to make to obtain that benefit. The following details the qualifying events and the maximum continuation under the Plan if COBRA continuation coverage is available.

- a) Termination of Employment (voluntary or involuntary but for reasons other than gross misconduct);
- b) Reduced Work Hours whereby the Employee is no longer eligible under the Plan;
- c) Death of the Employee;
- d) Divorce or legal separation;
- e) Medicare Entitlement (resulting in a loss of coverage); or
- f) Loss of Dependent Status.

Notwithstanding the foregoing, Qualified Beneficiaries who become disabled prior to or within sixty (60) days of the COBRA Start date, shall be eligible for an eleven (11) month extension; providing a maximum of twenty-nine (29) months of continuation coverage. The Plan Administrator must be notified by the Participant (or agent) of disability determination by Social Security Administration within sixty (60) days of the Participant's receipt of that determination and within the first eighteen (18) months of COBRA continuation. In addition, Dependents are required to notify the Plan Administrator of a qualifying event within sixty (60) days from the date of a divorce, legal separation, loss of dependent status or Medicare Entitlement.

9.2 Notification Requirements - Employees shall receive an initial COBRA notification informing them of their rights and responsibilities under COBRA. When a qualifying event is experienced, the Employer shall send a letter to the Qualified Beneficiaries detailing their options under COBRA. Employers are also responsible to send a Conversion Notice (if applicable), an Unavailability of COBRA Notice and a Termination Notice.

9.3 Coverage Type - Qualified Beneficiaries who elect to continue under COBRA shall receive the same benefits under the Plan as a similarly situated active Employee..

9.4 Acceptance Procedure - Qualified Beneficiaries electing to continue coverage have sixty (60) days from the later of the date of the qualifying event notification or the date coverage is lost to notify the Employer of their decision to continue. Qualified Beneficiaries shall complete the appropriate COBRA continuation applications and return to the Employer immediately. Coverage will be reinstated retroactively to the last day of coverage so that there is no lapse in coverage.

9.5 Premium Contributions - The Qualified Beneficiaries are responsible for making full Plan Contributions for coverage in which they elected to continue. Rates shall be based upon a similarly situated active Employee electing the same Benefit plus a two percent administration charge. Payments may be prepaid or on a monthly basis. Upon accepting COBRA continuation coverage, the Qualified Beneficiary shall make the initial payment within forty-five (45) days. Subsequent premium payments are due on the first of the month. There is a thirty (30) day grace period for late payments. If a Participant does not pay his premiums within this time frame, his coverage shall terminate.

9.6 COBRA Termination - Individuals continuing under COBRA will be terminated from the Health Reimbursement Plan upon the earliest date of the following events:

- a) Participant notifies the Employer of his decision to voluntarily terminate COBRA coverage; coverage shall end with the last day for which Plan Contributions were received;
- b) If the Participant does not make full Plan Contributions, coverage will be terminated on the last day funds were applied;
- c) Last day of the Plan Year;
- d) The date the Employer decides to terminate the Plan and all other group health plans for all active Employees; or
- e) The date the Participant becomes entitled to Medicare after making his COBRA election.

Section 10

Miscellaneous

10.1 Amendment and Termination - The Employer may amend the Plan at anytime, retroactively if necessary, to maintain the Plan's compliance under the Code. The Employer may also terminate the Plan at anytime, provided that no amendment, suspension or termination of the Plan may be made which would reduce or eliminate any accrued benefits (arising from incurred but unpaid claims) of Participants or their covered Dependents existing prior to the effective date of such termination.

10.2 No Employment Contract - The Plan shall not be deemed a contract of employment between the Employer and Participant. The Plan provides benefits to Employees but shall not guarantee or imply a Participant's continued employment. The Employer may terminate employment at anytime regardless of the effect the termination may have on the Participant or the Plan.

10.3 Nonassignability - Participants may not assign, sell or transfer benefits of the Plan to another Employee, Participant or any other individual.

10.4 Facility of Payment - If the Plan Administrator deems a Participant, spouse or other Dependent incapable of receiving benefits, the Plan Administrator shall direct the Employer to provide benefits to a designated (or at the Plan Administrator's discretion if not designated) individual. Any such facility of Payment shall be made in accordance with the Plan and the Code.

10.5 Required Information - Participants shall provide the Plan Administrator all information relative to the efficient operation of the Plan. The Plan Administrator shall not be required to seek or investigate for Participant information that is needed for the correct administration of the Plan. The Plan Administrator shall have the right to request additional information from a Participant or covered Dependent if there are any ambiguities or inconsistencies with a claim or an elected benefit.

10.6 Assumed Compliance - The Employer believes that the Plan is in compliance with the Code and other related legislation or court decisions. The Plan has not been submitted to the governing bodies for approval, therefore shall not guarantee the Participant's reduced tax liability. Participants enrolling in the Plan shall assume any tax consequences upon the Plan being deemed invalid or in noncompliance. If the Plan is deemed invalid or in noncompliance, the Employer shall either terminate the Plan or take the appropriate actions to regain compliance.

10.7 Plan Funds - The Employer shall not utilize or divert Participant Plan Contributions for purposes other than the intended use of the Benefits described under the Plan Document. Excess or forfeited funds may be used for Plan administration expenses (or as explained in Section 6.7) but cannot be used to reimburse a Participant without a substantiated claim

10.8 Severability - If any provision under the Plan is deemed invalid or in noncompliance with the Code, it shall not affect the remaining provisions and the Plan shall continue as if the invalid provision was never part of the Plan.

10.9 Certain Conflicts - Notwithstanding any other provision of this Plan, to the extent any provision herein conflicts with any provision set forth in a Component Plan, the provision of such plan will control.

10.10 Construction - The masculine gender, where appearing in the Plan, shall include the feminine gender, and vice versa, and the singular may include the plural, unless the context clearly indicates to the contrary. The term "delivered to the Plan Administrator," as used in the Plan, shall include delivery to a person or persons designated by the Plan Administrator for the disbursement and receipt of administrative forms. Delivery shall be deemed to have occurred only when the form or other communication is actually received. Headings and subheadings are for the purpose of reference only and are not to be considered in the construction of the Plan.

10.11 Applicable Laws - The Plan shall be construed and enforced according to the laws of the State of North Dakota to the extent not preempted by Federal law.

Section 11
Adoption of the Plan

11.1 Adoption of the Plan - The City of Mandan Health Reimbursement Plan is adopted by City of Mandan for the purpose as stated in Section 2.1 to be effective 01/01/2016 and provide benefits to Eligible Employees in a nondiscriminatory manner. This document is executed at _____ on the _____ day of _____, _____.

Authorized Representative's Signature

Print Name

Title

Witnessed By:

Witness Signature

Print Name

Witness Signature

Print Name