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Individual Coverage Health Reimbursement Arrangement

Effective _____, 20__

THIS IS A TEMPLATE DOCUMENT THAT CAN BE USED (ON AND AFTER **JANUARY 1, 2020**) BY SMALL EMPLOYERS WHO DO NOT OFFER GROUP HEALTH INSURANCE AND WANT TO REIMBURSE EMPLOYEES' INDIVIDUAL HEALTH INSURANCE POLICY PREMIUMS. BRETHREN BENEFIT TRUST RECOMMENDS YOU CONSULT WITH YOUR TAX OR LEGAL ADVISOR BEFORE ADOPTING THIS PLAN.

NOTE: EMPLOYERS WITH 50 OR MORE FULL-TIME EQUIVALENT EMPLOYEES SHOULD SEEK COUNSEL REGARDING THE IMPACT OF THIS PLAN ON THE EMPLOYER SHARED RESPONSIBILITY MANDATE UNDER THE AFFORDABLE CARE ACT. THIS PLAN MAY BE CONSIDERED AN OFFER OF COVERAGE, BUT IF BENEFITS DO NOT MEET AFFORDABILITY AND MINIMUM VALUE REQUIREMENTS, THE EMPLOYER COULD BE SUBJECT TO A PENALTY.

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INTRODUCTION

The _____ Individual Coverage Health Reimbursement Arrangement (the "Plan") was established to provide Eligible Employees of _____ ("Employer" and "Plan Administrator") with the opportunity to receive pre-tax reimbursement of individual health insurance policy premiums. This document constitutes the Plan, effective_____, 20__.

This Plan is funded solely by the Employer and reimburses individual health insurance policy premiums of an employee and dependents up to a maximum amount established by the Employer each year. The Plan is offered as a means for reimbursing employees for their purchase of individual health insurance coverage on a pre-tax basis. A Participant must be enrolled in the Plan as a condition of participation in the Plan.

The Employer reserves the right to alter, amend, modify or terminate the Plan, in whole or in part, at any time, for any reason, in a manner consistent with the provisions of Article VII.

This Plan is sponsored by a not-for-profit church organization and is intended to be a church plan and thus exempt from the Employee Retirement Income Security Act of 1974 ("ERISA"). It is intended to be an individual coverage health reimbursement arrangement as defined in the Internal Revenue Code of 1986, as amended. The Plan is a group health plan integrated with individual health insurance coverage.

As required by federal law, the marital status of an employee under this Plan must be determined by federal law. As a result, only a spouse of an Eligible Employee as defined under Federal law will qualify for benefits as a spouse under this Plan unless the covered individual qualifies as a dependent under section 152 of the Code.

This document, as it may be duly amended, shall constitute the Plan in its entirety. In the event any discrepancies exist between this document and any amendment, the amendment shall govern.

This Plan is intended to qualify as an individual coverage health reimbursement arrangement within the meaning of the Code, so that the benefits provided under the Plan shall be eligible for exclusion from each employee's income for federal income tax purposes if all requirements applicable to an individual coverage health reimbursement arrangement are met. The provisions of this Plan shall be interpreted in accordance with that intent.

I

DEFINITIONS

The following capitalized words and phrases, when used in the text of this document and any attachment or materials incorporated herein or amendment hereto, have the meanings set forth below. Wherever any words are used in the singular form, they shall be construed as if they were also used in the plural form in all cases where the plural form would so apply, and vice versa. If a definition includes rules regarding the definition, those rules shall apply.

Claim Administrator

"Claim Administrator" means _____, or a designated proxy appointed by the Employer as described in Section 6.02, who shall process all or a designated portion of the claims under this Plan in accordance with the Plan's terms.

Class

An Employer must offer the Plan on the same basis to all individuals within a "Class" of employees – permissible Classes are listed below. The Employer can choose to offer the Plan to all employees, or only certain Classes of employees.

- Full-time employees
- Part-time employees
- Employees working in the same geographic location (generally, the same insurance rating area, state, or multi-state region)
- Seasonal employees
- Employees in a unit of employees covered by a particular collective bargaining agreement
- Employees who have not satisfied a waiting period
- Non-resident aliens with no U.S. source income
- Salaried workers
- Non-salaried workers (such as hourly workers)
- Temporary employees of staffing firms
- Any group of employees formed by combining to or more of the above classes

Code

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

Dependent

"Dependent" means any individual who is a dependent of the Employee within the meaning of section 152 of the Code, as modified by statute, regulation, or otherwise.

Effective Date

"Effective Date" means_____, 20__. The Effective Date of any amendment or restatement of the Plan is the effective date specified in the amendment or restatement.

Eligible Employee

"Eligible Employee" means an individual who is an Eligible Employee within the meaning of Section 2.01.

Employer

"Employer" means _____.

Enrollment Form

"Enrollment Form" means an enrollment and attestation form prescribed by the Plan Administrator for purposes of enrolling for coverage under the Plan. Participants are required to verify proof of enrollment in individual health insurance coverage or Medicare Parts A, B or C at the time of enrollment in the Plan and on an annual basis thereafter. A model attestation form is attached as Appendix A.

Health Care Expense

"Health Care Expense" means any amount incurred by a Participant, covered Dependent, and Spouse that is an expense for individual health insurance policy premiums not reimbursed by any other health care plan. The Plan Administrator shall determine whether an amount constitutes a Health Care Expense that qualifies for reimbursement hereunder.

In order for the Plan to reimburse individual health insurance policy premiums tax-free, the individual health insurance policy must offer minimum essential coverage as defined by the Affordable Care Act.

Short-term limited duration health insurance; coverage consisting solely of dental, vision, or similar excepted benefits; and health care sharing ministry programs are not considered health insurance, and premium payments to and under these programs cannot be reimbursed under the Plan.

HRA Account

An "HRA Account" is the account established by the employer for each Eligible Employee in which employer contributions are deposited, to be used to reimburse the Participants for eligible and approved Health Care Expenses. Any amounts remaining in an Eligible Employee's HRA Account at the end of the Plan Year will be forfeited.

Participant

"Participant" means any Eligible Employee who meets the requirements for participation under this Plan and for whom coverage is in effect under this Plan.

Period of Coverage

"Period of Coverage" means the Plan Year, except that:

(a) for Eligible Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 2.01; and

(b) for Eligible Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 2.02.

Plan

"Plan" means the _____Individual Coverage Health Reimbursement Arrangement, as described herein and as amended from time to time.

Plan Administrator

"Plan Administrator" means the Employer.

Plan Year

"Plan Year" means the period beginning January 1 and ending December 31.

Spouse

"Spouse" means "spouse" as defined under federal law.

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ELIGIBILITY AND ENROLLMENT

2.01 Eligibility

Eligible Employees who are not eligible to participate in other group health plans provided by the Employer may participate in the Plan as described below:

(a) An active employee in a Class covered under the Plan on the day before the Effective Date who otherwise meets the requirements of this Section 2.01 shall be eligible to participate in this Plan beginning on the Effective Date.

(b) Each newly hired or reemployed active employee in a Class covered under the Plan shall be eligible to participate in the Plan upon employment or reemployment.

(c) No Eligible Employee in a covered Class shall become a Participant unless the Eligible Employee submits an Enrollment Form in accordance with the rules set forth in Section 2.02.

2.02 Enrollment

An Eligible Employee must enroll in the Plan to commence participation in the Plan. An Enrollment Form must be completed, executed, and returned to the Plan Administrator. Such coverage will be effective as soon as administratively possible, but no later than 30 days after the completed Enrollment Form is received by the Plan. If the Plan Administrator does not receive a properly completed Enrollment Form by the last day of the applicable time period, the Eligible Employee shall not be covered under the Plan.

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TERMINATION OF BENEFITS

3.01 Termination of Coverage

An individual's participation in the Plan shall terminate as of the earliest of:

(a) the date the individual opts out of coverage under the Plan;

(b) the date the individual ceases to be employed by the Employer;

(c) the date of this Plan's termination; or

(d) the date as of which an individual dies, retires or otherwise ceases to be an Eligible Employee.

Reimbursements after termination of participation in the Plan will be made in accordance with Section 4.06 of the Plan.

3.02 Annual Opt Out Opportunity

Participants must be permitted to opt out of the Plan at least annually in accordance with applicable regulatory requirements.

3.03 Coverage Following Termination of Employment

Federal law does not require church health plans to provide continuation coverage after termination of employment. However, the Employer may be required to provide continuation coverage under this Plan under applicable state law.

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REIMBURSEMENT BENEFITS

4.01 Provision of Benefits

(a) The benefits available under this Plan for a Plan Year shall take the form of reimbursements for Health Care Expenses during the Period of Coverage. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses incurred after participation has commenced and before participation has ceased.

(b) The Employer shall bear the entire expense of providing the benefits set forth in this Section 4.01. All payments shall be made from the HRA Account established in each Eligible Employee's name. The employee may not contribute to his or her HRA Account.

4.02 Contributions and Funding

(a) The Employer will establish and maintain an HRA Account with respect to each Participant and will maintain separate and discrete accounts for Participants under this Plan.

(b) The Employer may establish rules, in addition to those already prescribed hereunder, for the timeliness of contributions to be made into each Participant's HRA Account.

(c) An amount remaining in a Participant's HRA Account at the end of a Plan Year cannot be transferred or rolled over to the next Plan Year. All amounts remaining in an HRA Account at the end of the Plan Year (after all reimbursements for eligible Health Care Expenses have been made) will be forfeited by the Participant and paid to the Employer.

Employer contributions and limitations on reimbursement described in Section 4.03 shall be prorated to reflect participation during a period shorter than the entire Plan Year.

4.03 Limitations on Reimbursements and Forfeitures

Notwithstanding any provision of this Plan to the contrary, the Participant's reimbursement under this Plan for any Plan Year shall be limited to the smallest of the following:

(a) the Participant's eligible Health Care Expenses for the Plan Year;

(b) the annual maximum amount described in Section 4.04; or

(c) any limitation established with respect to the Participant pursuant to Sections 4.06 or 8.02.

All contributions and limitations on reimbursement shall be prorated to reflect participation during a period shorter than the entire Plan Year.

4.04 Annual Limits

The Employer determines the annual maximum amount that a Participant may have credited to a Participant's HRA Account for an entire 12-month Plan Year. Contribution amounts may vary by Class, and may change each year.

The Employer must contribute the same amount on the same terms for each Class of Participants, except that Employers can increase the amount available based on the Participant's number of dependents or age; provided however, that the maximum amount available to the oldest Class Participant cannot be more than three times more than the maximum amount available to the youngest Class Participant.

4.05 No HRA Account Carryover

As provided in Section 4.02(c), if any balance remains in the Participant's HRA Account for a Plan Year after all Health Care Expenses have been reimbursed for the Plan Year, such balance shall not be carried over to reimburse the Participant for Health Care Expenses during a subsequent Plan Year.

4.06 Expense Reimbursement Procedure

Reimbursement of Health Care Expenses shall be made in accordance with the following procedures:

(a) To receive reimbursement for Health Care Expenses under this Plan, a Participant must submit a written application to the Claim Administrator not later than 30 days following the end of the Plan Year in which such Health Care Expenses were billed to the Participant, or if earlier, within 30 days of a Participant's termination of employment, in accordance with such rules, practices and procedures as the Claim Administrator may specify for the reimbursement of Health Care Expenses under the Plan.

(b) Each request for reimbursement shall include such substantiation as required by the Claim Administrator, which may include the following information:

(i) the name and address of the employee;

(ii) the name of the person to whom the Health Care Expense relates, and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant and a statement that such person is a Dependent of such Participant; and

(iii) the name and address of the organization to whom the Health Care Expense was or is to be paid and the amount of the Health Care expense.

The Claim Administrator may require the Participant to furnish a bill, receipt, canceled check, or other written evidence or certification of payment or of an obligation to pay Health Care Expenses.

Substantiation of individual health insurance coverage, or Medicare Part A, B or C coverage will also be required at the time of reimbursement. A model attestation form is attached as Appendix A.

(c) Subject to applicable law, the Employer may establish such rules as it deems desirable regarding the frequency of reimbursement of Health Care Expenses and the minimum dollar amount that may be requested for reimbursement.

4.07 Coordination with Other Sources, Including Flexible Spending Accounts

Reimbursement of Health Care Expenses under this Plan shall be permitted only to the extent that such Health Care Expenses have not been previously reimbursed by any other plan or account.

Any portion of an individual health insurance premium for coverage not provided on a public exchange and which is not covered under this Plan may be paid on a pre-tax basis by the employee using a salary reduction under the Employer's cafeteria plan, if available and if the Employer permits such reimbursement.

4.08 Impact on Premium Tax Credits

Participation in this Plan is considered an offer of coverage under the Affordable Care Act. An individual will not be eligible for a premium tax credit if enrolled in this Plan and the Plan is considered to be affordable and provides minimum value. A Participant who has opted out of coverage under this Plan may be eligible for a premium tax credit only if the Plan is not considered to be affordable or does not provide minimum value.

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PAYMENT OF BENEFITS

5.01 Application for Benefits

To be entitled to reimbursement under this Plan, a Participant must comply with the rules the Claim Administrator has established for claiming benefits, including, without limitation, the completion and filing of a written application and the provision of certain information, as described in Section 4.06.

5.02 Assignment of Benefits

Except to the extent provided in this Plan, no benefit payable at any time under this Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge or bankruptcy): the Plan, the Plan Administrator, the Claim Administrator and the Employer.

5.03 Payment to Representative

In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under this Plan, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under the Plan remain unpaid, the Plan Administrator may direct the Claim Administrator to make direct payment to the executors or administrators of the Participant's estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Plan and the obligations of the Plan Administrator, the Claim Administrator and the Employer.

5.04 Responsibility for Payment

It is the Participant's responsibility, in all cases, to pay for Health Care Expenses. Any benefit payment made directly to a Participant or the Participant's representative (as described in Section 5.03) for a Health Care Expense shall completely discharge all liability of this Plan, the Claim Administrator, the Plan Administrator and the Employer with respect to such expense.

5.05 Overpayments

If, for any reason, any benefit under this Plan is erroneously paid or exceeds the amount payable on account of a Participant's Health Care Expenses, the Participant shall be responsible for refunding the overpayment to the Plan. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable under the Plan, or any other method the Plan Administrator, in its sole discretion, may require.

5.06 Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Claim Administrator, the Plan Administrator and the Employer shall have no obligation or duty to locate a Participant. In the event a Participant becomes entitled to payment under this Plan and such payment cannot be made, for any reason, the amount of such payment, if and when made, shall be determined under the provisions of the Plan without any provision for interest on payments which may have accrued.

5.07 Missing Person

If, within two years after any amount becomes payable under this Plan to a Participant, the Participant has not accepted or made himself or herself available to receive the reimbursement, the amount shall be forfeited to the Employer and shall cease to be a liability of this Plan.

5.08 Fraudulent Claims

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, and the Claim Administrator may refuse to honor any claim under the Plan.

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ADMINISTRATION OF THE PLAN

6.01 Administration of the Plan

The Employer shall serve as Plan Administrator responsible for the administration of the Plan and shall make all determinations under the eligibility provisions set forth in Article II of the Plan. The Employer, acting as Plan Administrator, may assign or delegate any of its responsibilities for administering this Plan or carrying out its provisions. To the extent of any such assignment or delegation, the assignee or delegate shall have all of the authority and powers of the Employer granted by the Employer. Any action taken by the Employer assigning any of its responsibilities as Plan Administrator to specific persons who are directors, officers, or employees of the Employer shall not constitute delegation of the Employer's responsibility, but rather shall be treated as the manner in which the Employer acting as Plan Administrator has determined internally to discharge such responsibilities.

6.02 Appointment of Claim Administrator

The Employer may appoint one or more Claim Administrators to process all or a designated portion of claims under this Plan in accordance with its terms. If no Claim Administrator is appointed, the Employer shall serve as the Claim Administrator. The person, persons, entity or entities serving as Claim Administrator shall serve at the pleasure of the Employer. The Claim Administrator shall have the authority and discretion to interpret the Plan with respect to its duties and to decide questions and disputes arising under the Plan with respect to such duties, which interpretations and decisions shall be final and binding for purposes of the Plan, subject to any right of Participants to appeal the interpretation and decisions under this Plan.

6.03 Powers of the Plan Administrator

The Plan Administrator is specifically given the discretionary authority and such powers as are necessary for the proper administration of this Plan, including, but not limited to, the following:

(a) to make claim decisions and benefit payments or direct the Claim Administrator to process all or a designated portion of claims and to make benefit payments to or on behalf of Participants entitled to benefits under this Plan;

(b) to have the authority and discretion to interpret the Plan, to decide questions and disputes, to supply omissions, to correct defects, and to resolve inconsistencies and ambiguities arising under the Plan, which interpretations and decisions shall be final and binding for purposes of this Plan;

(c) to authorize its agents to execute or deliver any instrument or make payments on the Plan Administrator's behalf;

(d) to obtain from Participants and others, such information as shall be necessary for the proper administration of this Plan, such as proof of other coverage and financial data needed to determine if an individual qualifies as the Dependent of an employee (e.g., income tax returns);

(e) to appoint committees with such authority and powers as the Plan Administrator deems necessary;

(f) to retain counsel, employ agents, and provide for such clerical, accounting, actuarial, consulting, claims processing, and other services as it deems necessary or desirable to assist it in the administration of this Plan;

(g) to retain the right, authority, and discretion to make claim payment and benefit decisions upon appeal to the extent it has the authority to make such appeal determinations under Section 6.04;

(h) to prescribe forms and procedures for enrollment, claim filing, and other administrative purposes under the Plan and to require their use for such purposes and, notwithstanding anything in this Plan to the contrary, to the extent permitted by applicable law, to establish and maintain a procedure whereby any submission requiring a written form may be made telephonically or electronically and whereby submissions made in accordance with such procedure shall be deemed to have been made as if on the applicable written form;

(i) to adopt rules for the administration of the Plan; and

(j) to maintain records of administration of the Plan.

No determination of the Plan Administrator or the Claim Administrator in one case shall create a precedent or require retroactive adjustment in any other case. Expenses for the administration of the Plan shall be paid by the Employer or out of forfeitures under the Plan.

6.04 Claims Procedure

The Claim Administrator shall review claims for benefits under this Plan and respond within 30 days after receiving the claim. This period may be extended for up to 15 days. If the claim is denied, the Claim Administrator shall provide written notification setting forth:

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

(b) specific reference to pertinent Plan provisions upon which the denial is based; and

(c) a description of any additional material or information necessary for the claimant to perfect the claim.

The claimant may request a review of a denied claim by the Plan Administrator. The claimant's request for review by the Plan Administrator must be submitted to the Plan

Administrator in writing within one hundred eighty (180) days of the claimant's receipt of a notice of denial from the Claim Administrator. The Plan Administrator shall respond within sixty (60) days after receiving a request for review. The Plan Administrator's decision shall be in writing and shall include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based.

6.05 Records and Reports

The Claim Administrator and Plan Administrator shall maintain all such books, accounts, records and other data as may be necessary for the proper administration of the Plan.

The Plan Administrator shall make available to each Participant, for examination at reasonable times during normal business hours, such records under the Plan in its possession as pertain to him.

6.06 Limitation on Liability

A Plan fiduciary shall be entitled to rely upon information from any source assumed reasonably and in good faith to be correct. The Plan Administrator and Claims Administrator shall not be subject to any liability with respect to its duties under this Plan unless it acts fraudulently or in bad faith.

6.07 Indemnification

To the extent permitted by law, the Employer shall indemnify and hold harmless each director, officer, or employee of the Employer to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs, and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities, and obligations under this Plan, other than such liabilities, costs, and expenses as may result from the gross negligence or willful misconduct of any such person or amounts paid by such person in a settlement to which the Employer does not consent. The Employer may obtain, pay for and keep current a policy or policies of insurance, insuring any of its employees who has any fiduciary responsibility with respect to this Plan from and against any and all liabilities, costs, and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities, and obligations under this Plan.

6.08 Notice

The Employer will provide an annual written notice to Eligible Employees not later than 90 days before the beginning of the Plan Year (or if an employee is not eligible to participate in the Plan as of the beginning of the Plan Year, the date on which the Eligible Employee is first eligible to participate in the Plan). The notice will contain the information required by Treasury Regulation section 1.9802-4(c)(6), including a description of the terms of the Plan and the maximum dollar amount available for each Participant, a statement of the right to opt out and waive further reimbursements from the Plan, a description of the potential availability of the premium tax credit for Participants who opt

out, a statement that the Participant must provide information regarding the amount of the Plan benefit to any health insurance exchange to which the employee applies for advance payment of a premium tax credit, and a statement that the Plan cannot reimburse any medical expense unless the required substantiation is provided. A model notice is attached as Appendix B.

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DURATION AND AMENDMENT OF THE PLAN

7.01 Right to Amend

The Employer reserves the right to amend the Plan at any time, in any manner, including, without limitation, the right to amend the Plan to reduce, add to or modify the type and amount of benefits provided for any and all Participants. Any amendment shall be formally adopted in writing. The Employer reserves the right to delegate this authority to amend, in whole or in part, to any committee, officer, or other person or persons as it deems appropriate.

7.02 Right to Terminate

Although the Employer intends to maintain this Plan for an indefinite period, the Employer reserves the absolute right to terminate or partially terminate the Plan at any time, for any reason by or pursuant to a resolution of the board of directors of the Employer. Any termination or partial termination of the Plan shall not adversely affect the payment of benefits to which a Participant was entitled under the Plan prior to the date of termination or partial termination. If the Plan is terminated, each Participant shall be entitled to benefits for Health Care Expenses incurred prior to the date of termination, provided that the Participant appropriately follows the terms of this Plan for reimbursement. Following Plan termination, the Employer shall have no liability or obligation to make any reimbursements under the Plan.

ARTICLE VIII
MISCELLANEOUS

8.01 Effect on Employment

Nothing in this Plan shall be construed as a contract of employment between the Employer and any of its employees. Participation in this Plan shall not lessen or otherwise affect the responsibilities of an employee to perform fully his duties in a satisfactory and businesslike manner, nor shall it affect the Employer's right to discipline, discharge, or take any other action with respect to any employee.

8.02 Effect on Benefits

Nothing in this Plan shall be construed as a guarantee that the Employer will continue to provide benefits to employees in the future.

8.03 Legal Compliance

The Employer may prospectively limit, reallocate or deny any benefit for a Participant or any group of Participants to the extent necessary to avoid discrimination under or otherwise comply with any pertinent provision of the Code or other applicable law.

8.04 Governing Law

This Plan shall be governed by and construed in accordance with applicable federal laws and, to the extent not superseded, with the laws of the State of _____. Benefits provided under this Plan are intended to be excluded from taxation under section 105 of the Code, and the Plan is intended to comply with any other Code sections as may be applicable to church plans for purposes of retaining such tax exclusion.

8.05 No Guarantee of Tax Consequences

Notwithstanding any provision of this Plan to the contrary, the Employer and the Plan Administrator make no commitment or guaranty that any amounts paid to or for the benefit or coverage of a Participant under this Plan shall be excludable from the Participant's gross income for federal, state or local income tax purposes, or that any other particular federal, state or local tax treatment shall apply or become available to any Participant as a result of the operation of this Plan. By accepting a benefit under this Plan, a Participant agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest or penalties that may be imposed in connection with the tax.

8.06 Invalid Provisions

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

Executed this _____ day of _____, 20____.

_____
EMPLOYER

By: _____
Name:
Title:

APPENDIX A – MODEL ATTESTATION FORM

APPENDIX B – MODEL NOTICE